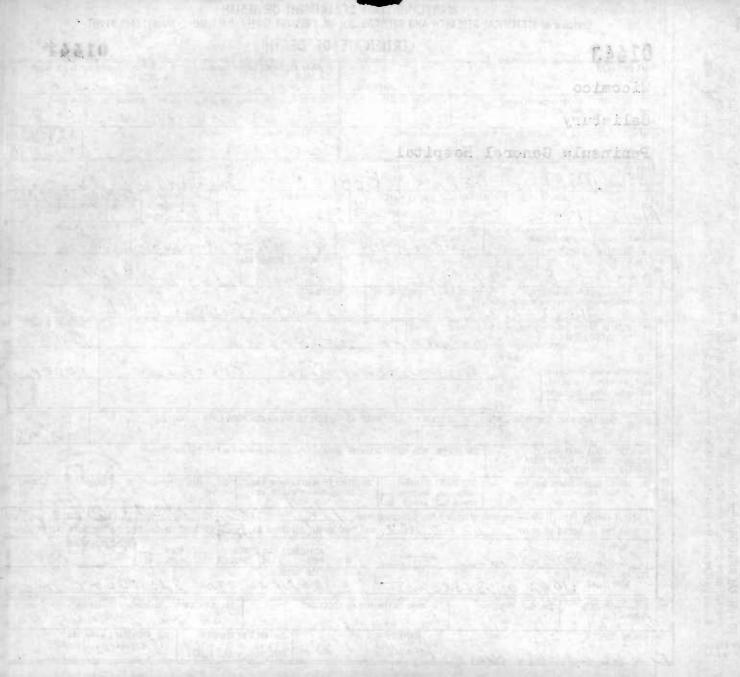
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MARYLAND STATE DEPARTMENT OF HEALTH



1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND								
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e State		saw the deceased alive on	and that	ATTENDING	MED STAFF	nd on the date stated above.			
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28	B	BURIAL, CREMATION, 236. DATE THEREOF	23%. NAME OF EMPFERY	OR CREMATORY	23d. LOCATION (City, fown	or county) Md (Stete)			
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 01445 death. burial-transit permit. Then please remave carban papers. Pages 1 and 2 burial, crematian, ar remaval, and in any event, within 72 hours after depth by the funeral Pages 1 and 2 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) O. COUNTY Wicomico b. COUNTY o. STATE MARYI AND Maryland Worcester certificate be executed within 24 hours after CITY OR TOWN (If outside carparote limits, write RURAL and give nearest tawn) c. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 Snow Hill Salisbury d. STREET ADDRESS IS RESIDENCE ON A FARM? .⊑ d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) campletely filled Market Street Peninsula General Hospital YES Noc 4 DATE 3. NAME OF Last Manth First Day Year DECEASED William Bowde 196 ANUARY (Type or print) DEATH IF JUNDER 1 YEAR IF UNDER 24 HRS. AGE (In years S. SEX 6. COLOR OR RACE DATE OF BIRTH 7. MARRIED NEVER MARRIED birthdoy) Months Days Hours WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or fareign country) 12. CITIZEN OF WHAT COUNTRY? **INDUSTRY** attending physician permit. Then please Virginia City Retired Policeman 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Martha Shockley Thomas Bowden 17. INFORMANT WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. requires that the death (Yes, na, ar unknawn) (If yes give wor ar dates af service) Mamie Bowden, Snow Hill, Md. No INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: signed by the burial-transit p ONSET AND DEATH IMMEDIATE CAUSE (o) Page 4 may be retained by the haspital ar attending physician. DUF TO Conditions, if ony, which gove rise to immediate cause (a). DUE TO stating the underlying cause has been as the priar ta last. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. use **TO FUNERAL DIRECTOR:** After this certificate ha director, page 3 shauld be detached far use shauld be filed with the State Dept. of Health I itu NO 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20e. PLACE OF INJURY (Home, form, (City or town) (Stote) 20c. TIME OF INJURY Month, Day, Yeor Hour a.m. 20d. INJURY OCCURRED 20f. (County) foctory, street, office bldg., etc.) Not While 19 ot wark at work 7 . 1967, that (1) (we) last 21. I certify that (1) (this hospital) attended the deceased fram -19 6 6 ta and that death accurred at 5.2% M, from causes and on the date stated above. saw the deceased alive an 1967 22b. DATE SIGNED 22a. SIGNATURE ATTENDING DIRECTOR M.D. PHYS. PHYS. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (State) 23a. BURIAL, CREMATION, Burial Bowen Methodist 1/16/67 Newark. k. Maryland 25b. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR. ADDRESS VR A15 (4) 20 M 1/66 Charle. Snow Hill. Maryland DATE

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 01446 death. within 24 hours after death by the funeral Pages 1 and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) d. COUNTY Wicomico o. STATE b. COUNTY burial, crematian, or removal, and in any event, within 72 hours after MARYLAND b. CITY OR TOWN (If autside carparate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) write RURAL and give nearest tawn) Salisbury filled in 1 e. IS RESIDENCE ON A FARM? and campletely filled in remave carban papers. d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) d. STREET ADDRESS Peninsula General Hospital YES NO X 3. NAME OF DATE Manth Year First Last Day DECEASED 196 (Type or print) DEATH executed IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX AGE (In years 6. COLOR OR RACE 7. MARRIED NEVER MARRIED last birthday) Manths Haurs WIDOWED DIVORCED 10a, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR ar fareign country) 12. CITIZEN OF WHAT requires that the death certificate be attending physician during most of working life, even if retired) INDUSTRY COUNTRY? 13. FATHER'S NAM 14. MOTHER'S MAIDEN NAME 17. INFORMANI 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO (Yes, no ar yhknown) (If yes give war or dotes of service) CAUSE OF DEATH (Enter only one cause per line for (g), (b), and (c).) signed by the burial-transit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY velene IMMEDIATE CAUSE (o) be retained by the haspital or attending physician. DUE TO Conditions, if ony, which gove rise ta immediate cause (a), DUE TO stating the underlying cause directar, page 3 shauld be detached for use as the should be filed with the State Dept. of Health prior to TO FUNERAL DIRECTOR: After this certificate has been 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE COMDITION GIVEN IN PART 1(a) NO ovalocy tosis 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER MEDICAL (Stote) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, 20f. (City or tawn) (County) 20c. TIME OF INJURY Manth, Day, Year Nat While factory, street, office bldg., etc.) 19 1- 7, 19 67 that (1) (vi) last 21. I certify that (I) (this haspital) attended the deceased fram. , 19 67 ta 19 6 7, and that death accurred at 6 5 M, from causes and an the date stated above saw the deceased alive an 22o. SIGNATURE 22b. DATE SIGNED ATTENDING M.D. DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S Page 4 may NAME (Type) 230/ BURIAL, CREMATION 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY LOCATION (City or Town) (County) (Stote) EMOVAL (Specify) uria 2Sb. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR Charles VR A15 (4) 20 M 1/66 DATE

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH be executed within 24 haurs after death. death 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 1. PLACE OF DEATH a. COUNTY
Wicomico a. STATE b. COUNTY Maryland Wicomico MARYLAND lease remave carban papers. Pages 1 and in any event, within 72 haurs after c. CITY DR TDWN (If autside carparate limits, write RURAL and give nearest tawn) b. CITY OR TOWN (If autside carparate limits. Acm. I THE STAY IN 16 write RURAL and give nearest town) 1/9/67 Salisbury Hebron filled in d. NAME OF HDSPITAL DR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE DN A FARM? Railroad Avenue NO F Peninsula General Hospital YES 3. NAME OF Last 4 DATE Month Day Year DECEASED BROWN BERTIE ESTHER 10 VAAUARU 1967 (Type or print) DEATH IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE 7. MARRIED 2 NEVER MARRIED 8. DATE OF BIRTH AGE (In years birthday) Manths Days 8 DIVORCED WIDOWED White Dec. 2. 1900 and 12. CITIZEN OF WHAT COUNTRY? 11. BIRTHPLACE (County & State, or fareign country) 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR physician a during most of working life, even if retired) **INDUSTRY** Hebron, Maryland requires that the death certificate 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME burial, crematian, or removal, Charles Wesley Phippin Mary Ellen Parsons 17. INFORMANT
Mr. Charles Henry Brown (Husband)
Railroad Avenue, Hebron, Maryland IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. permit. (Yes, na, ar unknawn) (If yes give war ar dates of service) 216-16-7601 No INTERVAL BETWEEN ONSET AND DEATH 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: signed by the burial-transit p IMMEDIATE CAUSE (a) Page 4 may be retained by the haspital ar attending physician. DUE TO Canditians, if any, which gave rise ta immediate cause (a), DUE TO stating the underlying cause O FUNERAL DIRECTOR: After this certificate has been director, page 3 shauld be detached far use as the PART II. OTHER SIGNIPICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(g) 19. WAS AUTOPSY PERFORMED? director, page 3 shauld be detached far use shauld be filed with the State Dept. of Health p NO 20g. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or town) (County) (State) 20c. TIME OF INJURY Manth, Day, Year factory, street, affice bldg., etc.) Nat While at wark at wark 21. I certify that (I) (this haspital) attended the deceased from 19\_\_\_, that (1) (we) last , and that death accurred at 7 95 M, fram causes and an the date stated abave. saw the deceased alive on 22b. DATE SIGNED 22a, SIGNATURE STAFF PHYS. Jan. 10 /1967 M.D. DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Salisbury, Maryland David 23d. LOCATION (City or Town) 23a. BURIAL, CREMATION 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (County) (State) REMOVAL (Specify)
Burial Hebron, Maryland Habron Cemetery HOLLOWAY & COMPANY, SALISBURY, MARYLAND 25b. REGISTRAR'S SIGNATURE 2Sa. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR lianely VR A15 (4) 20 M 1/66

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 01445 CERTIFICATE OF DEATH 01448 requires that the death certificate be executed within 24 hours after death and death 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) filled in by the funeral papers. Pages 1 and o. COUNTY o. STATE b. COUNTY Wicomica Maryland Wicomico MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) mon - 13 day Salisbury Salisbury d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? within 72 511 Douglas Place Deer's Head State Hospital YES NO X Middle 4. DATE carban First Lost Month Doy Year DECEASED 1967 M. Brown January Marion DEATH (Type or print) 1 YEAR IF UNDER 24 HRS. 9. AGE (In years IF UNDER B. DATE OF BIRTH S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED lost birthdoy) Months Doys Hours WIDOWED X DIVORCED Colored 1/4/1868 Female 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) hysician o **INDUSTRY** COUNTRY? Domestic 13. FATHER'S NAME Maryland
14. Mother's Maiden NAME Roland Dashiel Emley Quinton signed by the attending burial-transit permit. Th WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. (Yes, no, or unknown) ((If yes give wor or dotes of service 5 220-52-7982 Dolly Curtis 622 Lake St. Salis No cremation, INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) ONSEP AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate couse (a). DUE TO stoting the underlying couse the haspital ar attending this certificate has been the lost. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) ATTENDING PHYSICIAN: The NO far 205. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port 11 of item 18.) 20g. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED factory, street, office bldg., etc.) Hour o.m. Not While O FUNERAL DIRECTOR: After nto January], 19 67 that (1) (we) lost 21. I certify that (I) (this haspital) attended the deceased fram\_ be retained 0 saw the deceased glive an January 1. 1967, and that death accurred at 0:30M, from causes and an the date stated above. 220. SIGNATURE ATTENDING DIRECTOR M.D PHYS. page 22d. ADDRESS 22c, PHYSICIAN'S Deer's Head State Hospital MALDVE, MDD. NAME (Type) director, should 23d. LOCATION (City or Town) 23c. NAME OF CEMETERY OR CREMATORY 23o. BURIAL, CREMATION 23b. DATE THEREOF (County) (Stote) REMOVAL (Specify) Columbia ount Nebo Buria 2Sb. REGISTRAR'S SIGNATURE 250. REC'D BY REGISTRAR **ADDRESS** 24s FUNERAL DIRECTOR VR A15 (4) 196 20 M 1/66

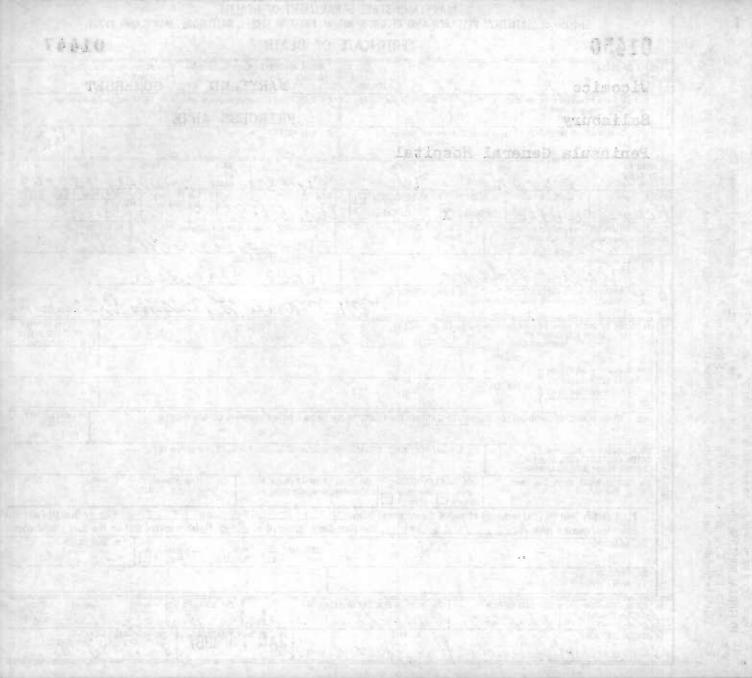
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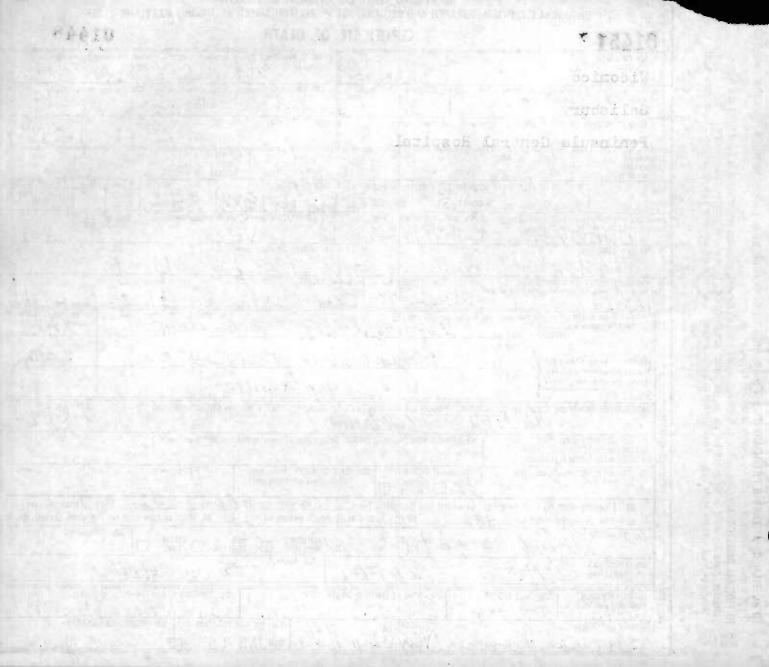
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 01449 CERTIFICATE OF DEATH 01446 executed within 24 hours after death death pup 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 1. PLACE OF DEATH a COLINTY o STATE b COUNTY Maryland MARYLAND BaltimoreCity Wicomico c. LENGTH OF STAY IN 1b b. CITY OR TOWN (If autside carparate limits. c. CITY OR TOWN (If autside corparate limits, write RURAL and give negrest town) write RURAL and give nearest town) since Baltimore, Md. 7/29/66 Salisbury completely filled in love carban papers. d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Pine Bluff State Hospital NO X 23 Eutaw Place YES [ Middle 3 NAME OF **Einst** Lost DATE Year DECEASED DEATH January 20 67 (Type or print) Archie Burrel1 9. AGE (In years lost birthday) IF UNDER 1 YEAR IF UNDER 24 HRS S SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED Months Hours male colored Nov. 6, 1932 DIVORCED WIDOWED 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & State, or fareign country) requires that the death certificate be **COUNTRY?** during most of working life, even if retired)

Laborer INDUSTRY U.S.A Baltimore City, Md 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME Johnnie Burrell Edna Cook Records of Pine Bluff State 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, na, ar unknawn) (If yes give war ar dates of service) 217-14-0464 Hospital, Salisbury, Md. INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) burial-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Pulmonary Tuberculosis IMMEDIATE CAUSE (a) vears DUE TO Conditions, if ony, which gove rise to immediate couse (o), **DUE TO** stating the underlying cause as the O FUNERAL DIRECTOR: After this certificate has been last. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II of item 18.) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (City or town) (County) (State) 20c. TIME OF INJURY Month, Day, Year factory, street, affice bldg., etc.) Nat While of wark at work 21. I certify that (14 (this haspital) attended the deceased fram July 29, 1966, to Jan. 20, 1967, that (14 (we) last saw the deceased alive an Jan. 20 19 67, and that death accurred at 11:18, fram causes and an the date stated above. 22b. DATE SIGNED 22a. SIGNATURE Jan. 20. 1967 120 M.D. DIRECTOR PHYS. 22d. ADDRESS Pine Bluff State Hospital 22c. PHYSICIAN'S NAME (Type) Ritchings. M.D. Salisbury, Maryland 23d. LOCATION (City or Jown) (County) (Stote) 23a. SURIAL, CREMATION, 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY REMOVAL (Specify) recome 25b. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR ADDRESS VR A15 (4) 20 M 1/66

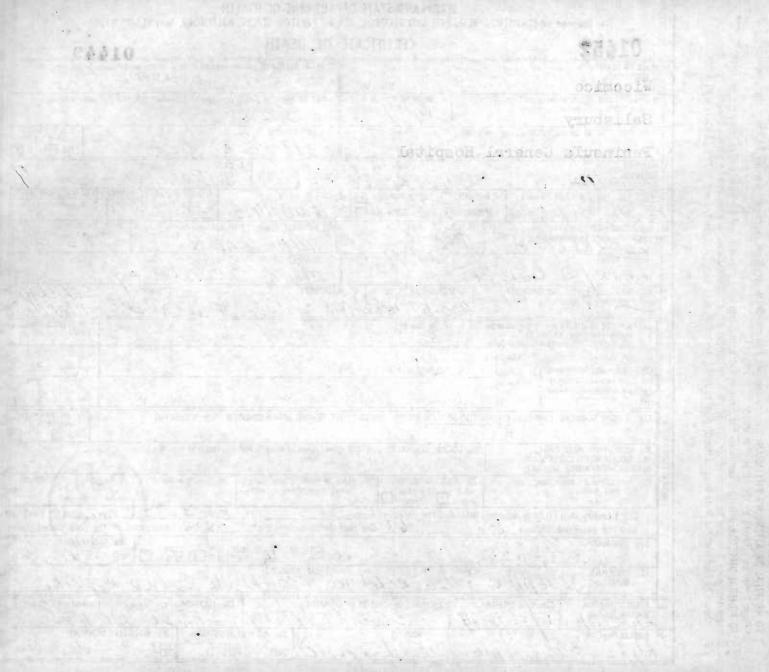
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 01450 CERTIFICATE OF DEATH 01447 and 2 within 24 hours after death. 2. USUAL RESIDENCE (Where deceosed lived, if institution; Residence before admission) PLACE OF DEATH completely filled in by the funeral ove corbon papers. Pages 1 and o. COUNTY Wicomico o. STATE MARYLAND MARYLAMD remove corbon papers. Pages 1 n ony event, within 72 hours ofter b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b PRINCESS ANNE Salisbury d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS 15 RESIDENCE ON A FARM? Peninsula General Hospital YES NO 3. NAME OF DATE Lost Month Doy Year DECEASED LEA 196 DEATH (Type or print) executed IF UNDER I YEAR IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE DATE OF BIRTH AGE (In years 7. MARRIED NEVER MARRIED birthdoy) Months Dovs Hours WIDOWED X DIVORCED ond in ony 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY physician certificate 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME attending pay. cremotion, or removol, INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 requires that the death permit. (Yes, no. or unknown) (If yes give wor or dotes of service) 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c),)
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MARYLAND STATE DEPARTMENT OF HEALTH



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral Ttem 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. COUNTY b. COUNTY \$ 7 E MARYLAND þ b. CITY OR TOWN (if outside corporate limits. LENGTH OF STAY IN 16 c. CITY OR TOWN of outside corporate limits, ferite RURAL and give neerest town) 24 Orite RURALand, give peacest town) ed in bages 1 after within ALOR INSTITUTION (if not in haspitel, give street address) . IS RESIDENCE AME OF HOSP d STREET ADDRESS hours ON A FARM papers. n 72 ho YES -NO 3. NAME OF Middle DATE Month Day Yeer 4. DECEASED OF carbon pe DEATH (Type or print) COLOR OR RACE 7. MARRIED AGE (In yeers | IF UNDER 1 YEAR IF UNDER B. DATE OF BIRTH 188 SEX NEVER MARRIED last birthday) Months Days Hours event, DIVORCED WIDOWED Then please remove BIRTHPLACE (County & Stete, or foreign country) WHAT COUNTRY? 10a. USUAL OCCUPATION (Give kind of work CITIZEN OF 10b. KIND OF BUSINESS OR INDUSTRY during most of working life, even if retirad) physic comece 2 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME removal, and 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. INFORMANT (Yes, no. or unkown) (Ifyesgivewerordetesofservice) the hospital or attending physician. After this certificate has been signed by 18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c). INTERVAL BETWEEN 50 ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) cremation, the burial-transit DUE TO Conditions, if eny, which geva rise to immediate cause burial, DUE TO (e), steting the underlying PHYSICIAN: cause lest. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE NOTION GIVEN IN PART 16 as 0 CERTIFICATION PERFORM prior detached for use NO 20a. ACCIDENT WAS UNDERLYING IT 20b. DESCRIBE HOW INJURY OCCURRED. (Enter neture of Injury in Pert I or Pert II of item 18.) Health OR CONTRIBUTING | CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) be retained by 20c. TIME OF INJURY 20d. INJURY OCCURRED I 20e. PLACE OF INJURY (Home, farm, 20f. (City or lown) (County) (Slele) Month, Day, Yeer jo factory, street, office bldg., etc.) Whila Not While Hour - o.m. DIRECTOR: et work et work State Dept. p.m. Pe 19 ( that (I) (we) last attended the deceased from ... plnous 21. I certify that (I) (this hospital) The causes and on the date stated above. saw the deceased alive on. ..... and that death occurred a DATE 22e. SIGNA 22Ь. ATTENDING page with th FUNERAL PHYS. DIRECTOR PHYS. M.D. Page 22c. PHYSICIAN 22d. AD RESS filed v (State) 23a. BURIAL, CREMATION, 1 23b. DATE THEREOF 23c. MAME OF CEMETERY OR CREMATORY LOCATION (City, town or county A Fig REMOVAL (Specify) 25a. REC'D BY REGISTRAR'S SIGNATURE REGISTRAR 24 FUNERAL DIRECTOR'S SIGNATURE VR A15 (4) DATE 20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH

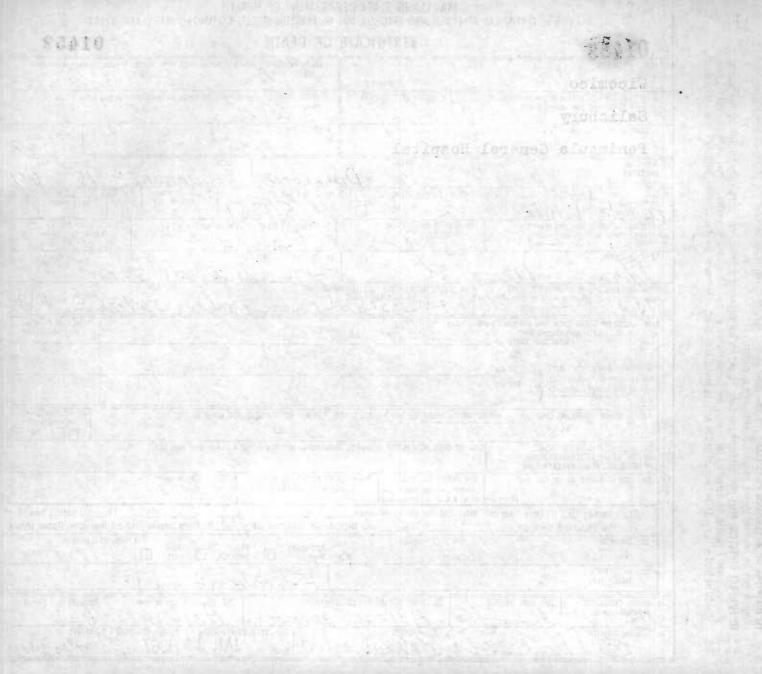
MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
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7	1(1/1)		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
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	bing PHYSICIAN: The law requires that the death certificate of by the hospital or attending physician.  After this certificate has been signed by the attending phys dedetached for use as the burial-transit permit. Then ple	CE OR	DA: ACCIDENT WAS UNDERLYING     20b. DESCRIBE HOW INJURY OCCURREO. (Enter nature of Injury in Part I or Part II of Item 18.)   CONTRIBUTING   CAUSE DF OEATH     FEITHER, NOTIFY MEDICAL EXAMINER)
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	retained retained rector. A 3 should with the		saw the deceased alive on 122 1964, and that death occurred at 2:10 m from the causes and on the date stated above
	OR be		Theese history M.D. ATTENDING MEO. DIRECTOR   STAFF   1-4-67
	TO HOSPITAL OR ATTENDING Page 4 may be retained by TO FUNERAL DIRECTOR. After director, page 3 should be should be filed with the Stat	22	2c. PHYSICIAN'S NAME (Type) Philip A. Insley 22d. ADDRESS Salisbury, Md.
	HOS Page FUN FUN	23a. E	BURIAL, CREMATION, 23b. DATE THEREDF   23c. NAME OF CEMETERY OR CREMATORY   23d. LDCATION (City, town or county) (State)
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	D	24. F	UNERAL OIRECTOR ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 01459 01456 **O HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the haspital ar attending physician. and completely filled in by the funeral serious carbon papers. Pages I and in any event, within 72 hours after deat PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY a. STATE b. COUNTY Wicomico Wicomico Maryland MARYLAND c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest tawn) b. CITY OR TOWN (If autside carparate limits, c. LENGTH OF STAY IN 1b write RURAL and give nearest tawn) 103 days Salisbury Salisbury d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Rt. 4, Mt. Hermon Road Deer's Head State Hospital YES NO 3. NAME OF Middle 4. DATE **First** Last Day Year DECEASED OF DEATH 1967 Henry ELLIS January (Type or print) Norman IF UNDER 1 YEAR 9. AGE (In years IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE 8. DATE OF BIRTH 7. MARRIED NEVER MARRIED birthday) Haurs Days Jan. 9, 1905 DIVORCED WIDOWED White Male 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or fareign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? please the attending physician isit permit. Then please Wicomico County, Maryland Farmer Farming 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME burial, crematian, ar remaval, Annie Belle Dykes William Henry Ellis 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. INFORMANT (Yes, na, ar unknown) (If yes give war ar dates af service) Mrs. Lula May Smith (Sister) Willards, Maryland INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: signed by the burial-transit p O-LL Cays Broncho pneumonia IMMEDIATE CAUSE (a) DHE TO Inoperable CA of right mid lung with Conditions, if any, which gave rise to immediate cause (a), metastases (kidney, liver) DneYear DUE TO stating the underlying cause as the TO FUNERAL DIRECTOR: After this certificate has been PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) WAS AUTOPSY PERFORMED? (1) years) YES ANO Pulmonary Tbc., arrested far 20g. ACCIDENT WAS UNDERLYING 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH N/A (IF EITHER, NOTIFY MEDICAL EXAMINER 20e. PLACE OF INJURY (Hame, farm, 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED (City or town) (County) (State) factory, street, affice bldg., etc.) at wark 21. I certify that (1) (this haspital) attended the deceased fram October 6, 1966, to January 17, 1967, that (1) (we) last saw the deceased alive an January 17 19 67, and that death accurred at 7:29 A M, from causes and an the date stated above. 22b. DATE SIGNED 22a. SIGNATURE STAFF PHYS. ATTENDING 1/17/67 DIRECTOR M.D. PHYS. 22c. PHYSICIAN'S Dr. C. H. Winnacott Deer's Head State Hospital, Salisbury, Md. NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23a. BURIAL, CREMATION 23b. DATE THEREOF REMOVAL (Specify) Salisbury, Maryland Jan. 21.1967 Parsons Cemetery Burial 2Sa. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR "hanley 198 HOLLOWAY & COMPANY, SALISBURY, MARYLAND

MARYLAND STATE DEPARTMENT OF HEALTH

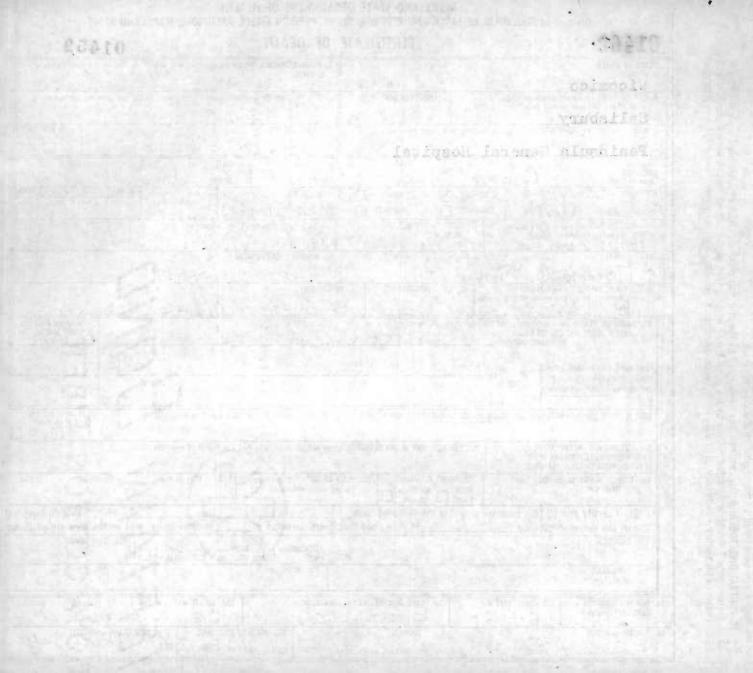
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 01461 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEPT. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY Wicomico b. COUNTY Wicomico o. STATE delay is and 3 to M3. Page of death. Maryland MARYLAND Deportment b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town) c. LENGTH OF STAY IN 3b with the State Deportm within 72 hours ofter Pittsville Salisbury d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e IS RESIDENCE ON A FARM? ffice olang with form mem 18. Give Poges 1, Peninsula General Hospital R.D. #1 YES NO hours after death. 3. NAME OF First Middle Last 4. DATE Month Year Doy DECEASED 1967 FARLOW MAGGIE ETHEL January (Type or print) DEATH with IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX B. DATE OF BIRTH 9. AGE (In years 6. COLOR OR RACE 7 MARRIED NEVER MARRIED lost birthdoy) Months 233 Hours 1881 March 24. White WIDOWED DIVORCED Female event 0 10o. USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT 10b. KIND OF BUSINESS OR during most of working life, even if retired) at hol COUNTRY ! Wicomico County, Maryland (= ) 24 dny home pages 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME This certificate should be executed within in penell = Mary Bratten Nelson Baker File and Mr. William L. Farlow (Son) 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dotes of service) word "pending" i the Chief Medicol or removal. 217-48-2071 Baker Street, Berlin, Maryland INTERVAL BETWEEN INSET AND PLATH 1B. CAUSE OF DEATH (Enter only one cause per line fox 6), (b), buriol-tronsit PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) ne certificate, writing the word should be forworded to the Ch burial, cremation, DUE TO Conditions, if ony, which gove rise to immediate couse (a) DUF TO 0 stoting the underlying couse SD 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) CERTIFICATION YES NO DE please execute the certificate, 9 20o. EXTERNAL CAUSE WAS PRIMARY → or CONTRIBUTING □ 20b. DESCRIBE HOW INJURY OCCURRED. (Ener noture of injury in Port I or Port II of item 1B.) ploods Health or its designated ogent, prior CAUSE OF DEATH MEDICAL 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote foctory, street, office bldg., etc.) your FUNERAL DIRECTOR: Page 2=14 1966 ot work 21. I certify that I taak charge of the remains described above, held an Autopsy Inspection X Inquiry X and in my opinion retoined for the funeral director. death resulted from Natural causes Homicide Undetermined manner Accident Suicide CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE January necessory, DEPUTY MEDICAL EXAMINER Earl L. Royer FXAMINED Dr. mov i NAME Type Address (Street, city, town, or county) Salisbury Md. / 23c. NAME OF CEMETERY OR CREMATORY Comden Ave. 23o. BURIAL, CREMATION 23b. DATE THEREOF 23d. LOCATION (City or Town) (County) 50 BEMOVAL (Specify) Pittsville, Maryland Jan. 20,1967 Pittsville Cemetery 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR Charley HOLLOWAY & COMPANY, SALISBURY, MARYLAND VR A15ME (5)

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH and in any event, within 72 hours after death. within 24 haurs after death by the funeral . Pages 1 and 2 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) d. COUNTY Wicomico b. COUNT MARYLAND b. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) Salisbury DAVIS filled in d. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital, give street address) papers. IS RESIDENCE ON A FARM? d. STREET ADDRESS Peninsula General Hospital YES NO ARDO pon 3. NAME OF Middle DATE Manth Last Doy Year completely DECEASED 1967 (Type ar print) DEATH anuany requires that the death certificate be executed S. SEX IF UNDER 1 YEAR 6. COLOR OR RACE 7. MARRIED B. DATE OF BIRTH 9. AGE (In years IF UNDER 24 HRS. NEVER MARRIED last birthday) Manths Days WIDOWED DIVORCED and 10a. USUAL OCCUPATION (Give kind af wark done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT COUNTRY? during mast af warking life, even if retired) physician INDUSTRY TUUSIS WILLER 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAM burial, crematian, ar removal, 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO INFORMANT Address (Yes, na, priunknown) (If yes; give wor or dotes of service CAUSE OF DEATH (Enter only one cause per line for (o) (b), and (c).) INTERVAL BETWEEN signed by the burial-transit PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (a) DUE TO Conditions, if ony, which gave rise to immediate cause (a), DUE TO far use as the t f Health priar ta b stating the underlying couse OFUNERAL DIRECTOR: After this certificate has been director, page 3 should be detached far use as the 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO YES | 4 may be retained by the hospital ar 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH director, page 3 should be detached should be filed with the State Dept. of (IF EITHER, NOTIFY MEDICAL EXAMINER 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20c. TIME OF INJURY Manth, Doy, Year (City or town) (County) (Stote) Haur a.m. factory, street, affice blda., etc.) Not While 19 at wark at work 21. I certify that (1) (this haspital) attended-the deceased fram\_ 20 - 600.19 ota. M, fram causes and an the date stated above. saw the deceased alive an , and that death accurred at 22a. SIGNATURE 22b. DATE SIGNED M.D. DIRECTOR PHYS. PHYS. 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY. 23g. BURIAL CREMATION. 23b. DATE THEREOF 23d. LOCATION (City or Town) (Stote) (County) REMOVAL (Specify) DUGRAREEN 24. FUNERAL DIRECTOR **ADDRESS** 2So. REC'D BY REGISTRAR REGISTRARIS SIGNATURE VR A15 (4) 20 M 1/66 0



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01463 FOR STATE 01460 HEALTH DEPT. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) delay 1. o. COUNTY o. STATE b. COUNTY Maryland Wicomico death. Wicomico of o MARYLAND ent c. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town) b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b Departme and give neorest town) Fruitland Selisbury d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? State De Office along with form Main Street, P.O. Box 253 YES NO X Item 18. Give Pages Peninsula General Hospital D.O.A. after death. 3. NAME OF Middle Lost 4 DATE Month Year Doy DECEASED 1967 JOHN FISHER ALVAH DEATH January (Type or print) IF UNDER I YEAR S. SEX AGE (In years IF UNDER 24 HRS. 6. COLOR OR RACE 7. MARRIED 1 NEVER MARRIED 8. DATE OF BIRTH lost birthdoy)
33 yrs. Months Days Hours Male White Nov. 20, 1933 WIDOWED DIVORCED haurs 7 event 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? INDUSTRY any Baltimore, Maryland Machine operator Chemical Co. Examiner's pages in any 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME within pencil Mildred Vincent Ashley Carl MacPherson Fisher File pup 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes no, or unknown) (If yes give wor or dotes of service) = 16. SOCIAL SECURITY NO. 17. INFORMANI Mrs. Mary Ann Fisher (Wife) executed rd "pending" in Chief Medical E permit. ar removal, P.O. Box 253. Fruitland. Maryland 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) burial-transit PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) certificate shauld writing the ward burial, crematian, DUE TO Conditions, if ony, which gove rise to immediate couse (o), DUE TO 0 stoting the underlying couse OS 19. WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) PERFORMED? This NO please execute the certificate. YES w agent, priar to pe should be 20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ Inter nature of injury in Port I or Port II of item 18.) 20b. DESCRIB 3 should MEDICAL EXAMINER: CAUSE OF DEATH. 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE\_OF INJURY (Home, form, (County) foctory, street, office bldg., etc.) Not While FUNERAL DIRECTOR: Page ot work the funeral director. Page designated 21. I certify that I taak charge of the remains described above, held an Autopsy Inspection X Inquiry and in my opinion for death resulted from: Accident Suicide Hamicide | Undetermined manner Natural causes be retained CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE O DEPUTY January 24 /1967 Earl L. Royer DEPUTY MEDICAL EXAMINER ar Dr. EXAMINER'S Health ( Address (Street, city, town, or county) NAME (Type) 409 Camden Avenue Salisbury, Md. 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) 23o. BURIAL CREMATION. 50 BEMOVAL (Specify) Allen, Wico. Co., Maryland Allen Church Cemetery Jan. 26,1967 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR 2So. REC'D BY REGISTRAR VR A15ME (5 HOLLOWAY & COMPANY, SALISBURY, MARYLAND

MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 01464 CERTIFICATE OF DEATH 01461 and 2 by the funeral Pages 1 and certificate be executed within 24 haurs after death 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) 1. PLACE OF DEATH ... Wicomico transit permit. The please remave carbon papers. Pages 1 cremation, ar remaval, and in any event, within 72 hours after **MARYLAND** b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside corparate limits, write RURAL and give nearest town) UPPER FAIRMOUNT Salisbury d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress) d. STREET ADDRESS IS RESIDENCE ON A FARM? completely filled in NO Peninsula General Hospital 3. NAME OF 4. DATE Year Lost , DECEASED ord 19 6 (Type or print) IF UNDER IF UNDER 24 ARS S. SEX OR RACE NEVER MARRIED 8. DATE OF BIRTH AGE (In years lost birthdoy) 1 YEAR Months Doys Hours DIVORCED NOV. 6.1882 84 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT 10b. KIND OF BUSINESS OR COUNTRY? CONDUCTOR UPPER FAIRMOUNT. U.S.A 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME THOMAS FORD CLARA FORD 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address requires that the death (Yes, no, or unknown) (If yes give wor or dotes of service MRS. CLARA HUBBARD ARDMORE. INTERVAL BETWEEN IB. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: signed by the burial-transit ONSET AND DEATH IMMEDIATE CAUSE (o) DUE TO burial, Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse Page 4 may be retained by the haspital ar attending as the has been PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (6) 19. WAS AUTOPSY PERFORMED? director, page 3 should be detached for use shauld be filed with the State Dept. af Health YES IN FUNERAL DIRECTOR: After this certificate 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH be detached (IF EITHER, NOTIFY MEDICAL EXAMINER MEDICAL 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Yeor foctory, street, office bldg., etc.) Not While ot work 21. I certify that (I) (this haspital) attended the deceased fram. 1-1567. 19\_, that (1) (we) last saw the deceased glive an 1-15-67 19 and that death accurred at 53 MM, fram causes and an the date stated abave. 22b. DATE SIGNED 22o. SIGNATURE M.D. DIRECTOR PHYS. 22d ADDRESS PHYSICIAN'S NAME (Type)

0 20 M 1/66

24. FUNERAL DIRECTOR LEVIN R. WILSON

23o. BURIAL, CREMATION

BURMOVAL (Specify)

23b. DATE THEREOF

1/19/1967

PRINCESS ANNE, MD.

23c. NAME OF CEMETERY OR CREMATORY

FAIRMOUNT

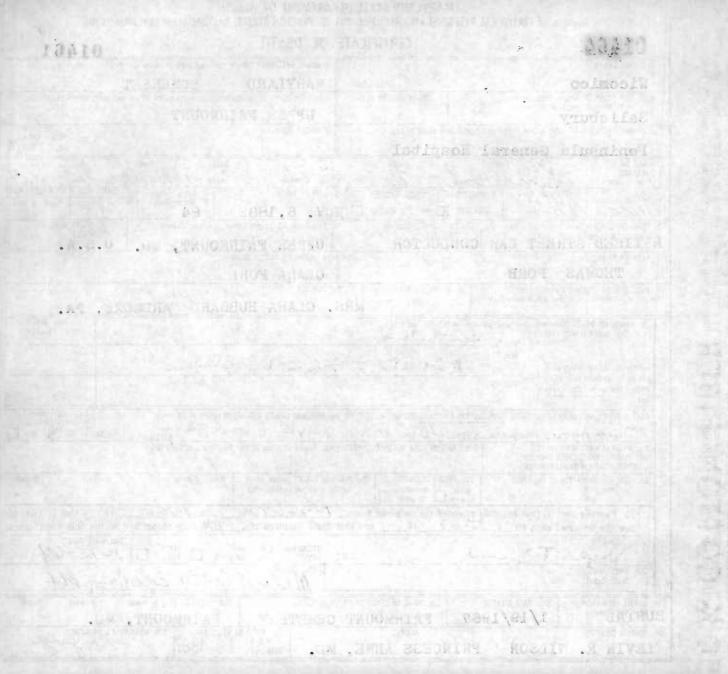
CEMETERY

FAIRMOUNT. MD. 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATUR

(County)

(Stote)

23d. LOCATION (City or Town)



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 01465 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01462 HEALTH DEPT. PLACE OF DEATH USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. STATE Maryland o. COUNTY b. COUNTY Wicomico Page 2 p af Wicomico death. MARYLAND delay 3 Department b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) and write RURAL and give nearest town) after Salisbury Salisbury d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e IS RESIDENCE ON A FARM? farm haurs the State [ Give Pages Peninsula General Hospital 907 Cooper Street NO IC YES 3. NAME OF First Middle 4 DATE Lost Month Dov Year DECEASED 167 NEVINS THOMAS FOSKEY January 23 (Type or print) DEATH with S. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 6. COLOR OR RACE X 8. DATE OF BIRTH AGE (In years 7. MARRIED NEVER MARRIED lost birthdoy) Months Days Hours in Item 18. Male White WIDOWED DIVORCED Sept. 21. 1940 24 haurs and 2 event 11. BIRTHPLACE (Stote or foreign country) 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT during most of working life, even if retired)

Machine Operator INDUSTRY COUNTRY? in any Salisbury, Maryland Nvlon Plant 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME be executed within in pencil Nevins Albert Foskey Lillian Virginia Beauchamp File pup WAS DECEASED EVER IN U.S. ARMED FORCES? Mrs. Lillian Luffman Foskey (Wife) 16. SOCIAL SECURITY NO permit. ie certiticate, writing the ward "pending" i shauld be farwarded ta the Chief Medical (Yes, no, or unknown) (If yes give wor or dotes of service)
Yes ar remayal, 907 Cooper St., Salisbury, Maryland CAUSE OF DEATH (Enter only one couse per line for (o), (b), on (c) INTERVAL BETWEEN burial-transit PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) certificate shauld writing the ward crematian, DUF TO Conditions, if ony, which gove rise to immediate couse (a). DUE TO stoting the underlying couse 0 go burial, o used PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? please execute the certificate. NO ţ pe 20o. EXTERNAL CAUSE WAS PRIMARY TO OF CONTRIBUTING (Enter noture of injury in Port I or agent, priar 3 should MEDICAL EXAMINER: CAUSE OF DEATH. 20d INJURY OCCURRED 20c. TIME OF INJURY Month, Doy, Year 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stota foctor, street, office bldg., etc.) Not While FUNERAL DIRECTOR: Page ot work designated 21. I certify that I taak charge of the remains described above, held an Autapsy far Inspection Inquiry and in my apinian Accident . Suicide [ death resulted from: Natural couses Hamicide Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE O DEPUTY Earl L. Royer January 24 or Dr. DEPUTY MEDICAL EXAMINER Health Address (Street, city, town, or county) 109 Camden Avenue. NAME (Type) Salisbury, Md. the 23h. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION (Stote) 50 Burial (Specify) 26,1967 Wicomico Memorial Park Salisbury, Maryland 2Sb. RIST CHAR'S SCHA 24. FUNERAL DIRECTOR 2So. REC'D BY REGISTRAR 196 VR A15ME (5) HOLLOWAY & COMPANY, SALISBURY, MARYLAND

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE IN 01463 HEALTH DEPT! PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. COUNTY o. STATE ny deloy is 2, and 3 to PM3. Poge b. COUNTY Wicomico Maryland Wicomico of within 72 hours offer deoth. MARYLAND b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) Parsonsburg Salisbury d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Examiner's Office olong with form Peninsula General Hospital Morris Leonard Rd. Item 18. Give Pages YES NO 3 NAME OF First Last 4. DATE Manth Year DECEASED JOHN FLWIN FOX 1-1-67 19 (Type or print) DEATH 9. AGE (In years last birthday) 8. DATE OF BIRTH IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE IF UNDER 1 YEAR 7. MARRIED NEVER MARRIED Months W 5-4-78 WIDOWED E DIVORCED event 10a. USUAL OCCUPATION (Give kind af wark dane during mast af warking life, even if retired) IDb. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT INDUSTRY USA COUNTRY? poges la in any e Missouri .⊑ Retired - Machinist Railroad 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME pencil (Unk.) Unk. Fox pup = 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no. ar unknawn) (If yes give war ar dates of service) Mr. James R. Bengel (Grandson) 182 Bridge Street, Phoenixville, Pa. 19460 16. SOCIAL SECURITY NO rd "pending" in Chief Medical E used as o buriol-transit permit. buriol, cremation, or removal, 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH Myocardial degeneration IMMEDIATE CAUSE (p) word This certificate should DUE TO Arteriosclerotic cardio-vascular disease Canditians, if any, which gave Years rise to immediate couse (o), DUF TO stoting the underlying couse PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? Fracture of right femur, intertrochanteric NO X please execute the certificate. designated ogent, prior to 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II of item 18.) 2Da. EXTERNAL CAUSE WAS PRIMARY Or CONTRIBUTING IN Fell at home. CAUSE OF DEATH. 2Dc. TIME OF INJURY Month, Day, Year 2Dd. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (City or town) (County) (State) 5 may be retained for your ...
TO FUNERAL DIRECTOR: Page 3
Health or its designated agen While at wark at wark factory, street, office bldg., etc.)
Own home 12-7-66 Parsonsburg, Wicomico, Md. Approx .p.m. 21. I certify that I tage charge of the remains described above, held an Autopsy Inspection X. Inquiry X ond in my opinion the funeral director. Notural causes . Accident X. Suicide Hamicide | Undetermined manner death resulted frame. CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE DEPUTY MEDICAL EXAMINER X January 9, 1967 Earl L. Royer, M EXAMINER'S 09 Camden Ave., Salisbury, Md Address (Street, city, town, or county) NAME (Type) 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION (County) (State) Cremation Jan. 6, 1967 University Hospital Baltimore, Maryland 250. RECA EX REGISTRAR 19675b. REGISTRARS SIGNATURA 24. FUNERAL DIRECTOR

DATE

Holloway Funeral Home, Salisbury, Md.

VR A15ME (\$)

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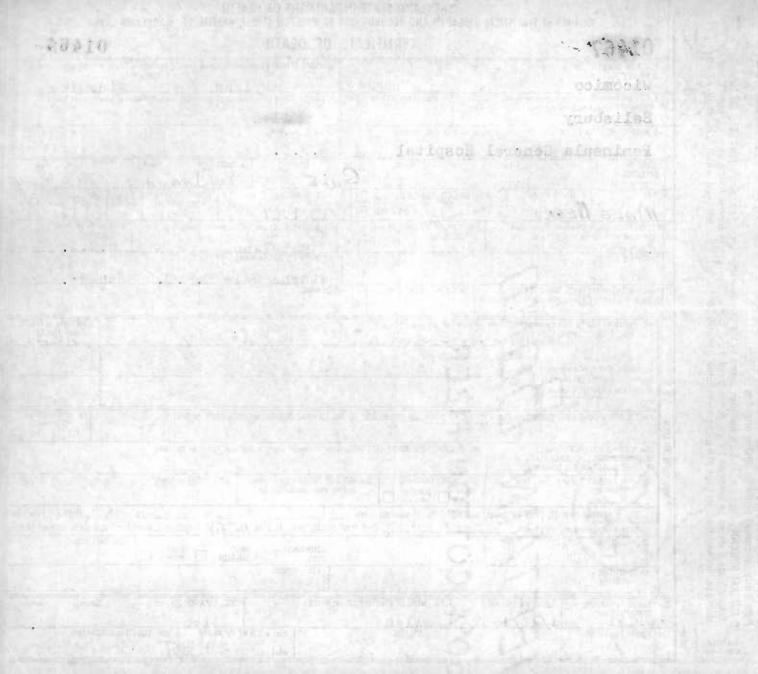
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 01464 01467 deoth/ PHYSICIAN: The low requires that the deoth certificate be executed within 24 hours after death and completely filled in by the funeral remove carbon papers. Pages 1 and PLACE OF DEATH USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) O. COUNTY Wicomico o. STATE Marvland MARYLAND ve carbon papers. Pages 1 event, within 72 hours after Wicomica b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) Allen Salisbury e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS Peninsula General Hospital R.F.D. #2 NO X 3. NAME OF 4. DATE Month Dov Year DECEASED 19 DEATH (Type or print) Ba by UNDER 1 YEAR S. SEX 6. COLOR OR RACE DATE OF BIRTH AGE (In veors IF UNDER 24 HRS. 7. MARRIED NEVER MARRIED lost birthdoy) Months Dovs Hours Min. WIDOWED DIVORCED EGRO 10/1967 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) during most of working life, even if retired) COUNTRY? INDUSTRY Maryland

14. MOTHER'S MAIDEN NAME Ja. FATHER'S NAME remov Bethena Gale R.F.D.2 Eden Md 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give wor or dotes of service) INTERVAL BETWEEN ONS AND DEATH 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) signed by the burial-transit PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUF TO burial. Conditions, if ony, which gove (b) rise to immediate couse (o), DUE TO for use os the t f Heolth prior to b stoting the underlying couse Page 4 may be retained by the hospital or attending O FUNERAL DIRECTOR: After this certificate has been lost. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) of Heolth p CERTIFICATION NO 20g. ACCIDENT WAS UNDERLYING [ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20d. INJURY OCCURRED 20f. 20c. TIME OF INJURY Month, Dov. Year foctory, street, office bldg., etc.) Hour o.m. Not While While ot work ot work 21. I certify that (1) (this haspital) attended the deceased fram. 1967 ta. 10 , 1967, that (1) (we) last and that death accurred at 11 4 M, fram causes and an the date stated above. Should saw the deceased alive on 22o. SIGNATURE 22b. DATE SIGNED ATTENDING director, page 3 should be filed w M.D. DIRECTOR PHYS. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 23o. BURIAL CREMATION. 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) Allen buria 2Sb. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR ADDRESS 2So. REC'D BY REGISTRAR VR A15 (4) 20 M 1/66 1967



, 1	DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
F 2ª F	01468 CERTIFICATE OF DEATH 01465
after death.  the funeral ges 1 and 2 after death.	1. PLACE OF DEATH a. COUNTY Wicomico  MARYLAND  2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission as STATE b. COUNTY Wicomico  MARYLAND  D. COUNTY Wicomico  MARYLAND
hours after d in by the rs. Pages 1 hours after	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  Salisbury  C. LENGTH OF STAY IN 15 Adm. in 1  Salisbury  C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  Salisbury
fille pape in 72	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  Peninsula General Hospital  d. STREET ADDRESS  e. IS RESIDENC ON A FARM?  YES \( \sum \) NO \( \sum \)
w w	3. NAME OF First Middle Last OF DECEASED (Type or print) NOAH JAMES GORDY DEATH January 17 1967
xecu and emo any	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 88. DATE OF BIRTH 99. AGE (In years list birthday) May 12, 1889 99. AGE (In years list birthday) Months Days Hours Min 77 yrs.
ician sase and ir	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  Retired - employee  10b. KIND OF BUSINESS OR industry  11. BIRTHPLACE (County & State, or foreign country)  COUNTRY?  Delmar, Maryland  12. CITIZEN OF WHAT COUNTRY?  USA
certificate nding phys	13. FATHER'S NAME  Benjamin Gordy  14. MOTHER'S MAIDEN NAME  Anna Bréwington
	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  No  16. SOCIAL SECURITY NO.   17. INFORMANT   Mr. Burton B. Gordy (Nephew)   131 Francis Dr., Salisbury, Maryland
The law requires that the death or attending physician. sate has been signed by the atter use as the burial-transit permit ealth prior to burial, cremation, or	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY:  Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.  ONE TO Conditions, Stating the underlying cause last.  ONE TO Conditions (b) Conditions (c)  DUE TO Conditions (c)
AN: pital pital of for	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)  19. WAS AUTOPS' PERFORMED? YES NO X  20a. ACCIDENT UNDERLYING TO PART II OF ITEM 18.)  19. WAS AUTOPS' PERFORMED? YES NO X  19. WAS AUTOPS'
PHYSI the h r this detacl	County   C
OR ATTENI or ATTENI y be retaine DIRECTOR: gg 3 shouli lied with the	21. I certify that (I) (this hospital) attended the deceased from
TO HOSPITAL Page 4 may TO FUNERAL director, pag should be fill	NAME (Type) Dr. Hubert R. White, Jr. Salisbury, Maryland  238. BURIAL CREMATION, 23b. DATE THEREOF   23c. NAME OF CEMETERY OR CREMATORY   23d. LOCATION (City, town or county) (State)
VR A15 (4) N	REMOVAL (Specify) Burjal Jan. 20, 1967 Parsons Cemetery 24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND  PARE  REMOVAL (Specify) Salisbury, Maryland 25a. REC'D BX REGISTRAR 25b. RECISTRAR'S SIGNATURE AND PARE  PARE
15M 4-64	DATE DATE

E48 : ( dina. Device to 1/o/1 The state of the s Market - e. deple Maria Committee - HOWHER WERE AND ASSESSMENT Wedles Will Live to the way Date Land , and have , . 1. heart 181 in description of the contract Dinasteane equitor said English Land 10, 1907 tarmount complete

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01469	CERTIFICATE	OF DEATH		01466	
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceo	b. COUNTY		
Wicomico	MARYLAND	Maryland Wicomico			
b. CITY OR TOWN (If outside corporate limits,	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corpore	te limits, write RURAL and give	e neorest town)	
write RURAL ond give neorest town) Salisbury		Salisbury		221	
d. NAME OF HOSPITAL OR INSTITUTION (If not in	hospitol, give street oddress)	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?	
Peninsula General	l Hospital	326 Glen A			
3. NAME OF First	Middle	Lost 4. DATE OF	Month	Doy Year	
(Type or print) SAMUEL	(NMI) (Ore	enheld DEATH	January	4 1967	
S. SEX 6. COLOR OR RACE 7.			P. AGE (In yeors / IF UNDER lost birthdoy) Months	Doys, Hours Min.	
male white V		May 8, 1899	O' Yrs.	26	
10o. USUAL OCCUPATION (Give kind of work done	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & Stote, or fo		TIZEN OF WHAT	
during most of working life, even if retired)  Owner - clothing mfg.	INDUSTRY	Austria	US		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Joel Greenfeld		Pauline			
15. WAS DECEASED EVER IN U.S. ARMED FORCES?	16. SOCIAL SECURITY NO. 17.	INFORMANT Mr. David M. Gree	Address		
(Yes, no, or unknown) (If γes give wor or dotes of ser	218-16-9171	Mr. David M. Gree 326 Glen Ave. Apt	mreid (Son)	Warmal on	
18. CAUSE OF DEATH (Enter only one couse p		JEO GTET WAR 'WILL	A Salish	INTERVAL BETWEEN	
PART I. DEATH WAS CAUSED BY:	14. 15 M12:	reardical	Interden	ONSET AND DEATH	
1 A 30 / IMMEDIATE CAUSE (o) _ DUE TO	7/0000			40 km.	
Conditions if any which gave	Com and la	le un caler or	20.	6000	
rise to immediate couse (a),	Court of			O'MO.	
stoting the underlying couse					
	OT ATTA ING TON THE HEAR OF SHITHING	THE TERMINAL DISEASE CONDITION CIVI	(N. IN. DADT 1/a)	19. WAS AUTOPSY	
PART II. OTHER SIGNIFICANT CONDITIONS CONTR	BUTING TO DEATH BUT NOT RELATED TO	THE TERMINAL DISEASE CONDITION GIVE	IN IN PART I(U)	PERFORMED?	
<u> </u>	Last present their hilling occupant	(F	• II - f :- 10 \	YES NO	
200. ACCIDENT WAS UNDERLYING   TO RECONTRIBUTING CAUSE OF DEATH  OF CONTRIBUTING TAMBER OF THE PROPERTY OF THE	20b. DESCRIBE HOW INJURY OCCURRED.	(Enter noture of injury in Port I or Pol	f II of Item 18.)		
	N/A		16		
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m.		ICE OF INJURY (Home, form, 20f.	(City or town) (Co	unty) (Stote)	
p.m. 17	at work L at work L	Joseph Jo	14	-	
21. I certify that (I) (this haspite	al) attended the deceased fram_	1/2/.19.6		hat (I) (we) last	
saw the deceased alive an	114 196 , and the	at death accurred at 1.3061	M, from couses and an t		
22o. SIGNATURE	11 01	ATTENDING MED.	STAFF 22b. D	ATE SIGNED	
, /	M.	D. PHYS. DIRECTOR	PHYS. Jan	4_/1967	
22c. PHYSICIAN'S		22d. ADDRESS			
NAME (Type) Dr. O.	J. Burton	Salisbury, l	aryland		
230. BURIAL, CREMATION, 23b. DATE THEREO	F 23c. NAME OF CEMETERY OR		OCATION (City or Town)	(County) (Stote)	
REMOVAL (Specify) Burial Jan. 5.	1967   Beth Israel	Cemetery Sa	lisbury, Mary		
24 FLINEDAL DIDECTOR	ADDRESS	250. REC'D BY REGIST			
HOLLOWAY & COMPANY,	SALISBURY, MARYLA	DATE	inno Whare	es Judge	

**D FUNERAL DIRECTOR:** After this certificate has been signed by the attending physican and campletely filled in by the funerol director, page 3 shauld be detached far use as the burial-transit permit. Then please remaye carbon papers. Pages 1 and 2 shauld be filed with the State Dept. af Health priar ta burial, crematian, or remayal, and in any event, within 72 haurs after death. 10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the d'ath certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been

VR A15 (4) 20 M 1/66

Commission of the commission o 31: 1 226 Wien Avenue, Apr. 202 ' ol Periosol (Proced Alesnics) 78 - 2899 B 767 an interest The passers Lago. BEALEY CONTRACTOR OF THE STATE The second of th money the comparison that med the transfer out the land WORKER , WHEN THE PROPERTY AND ADDRESS.

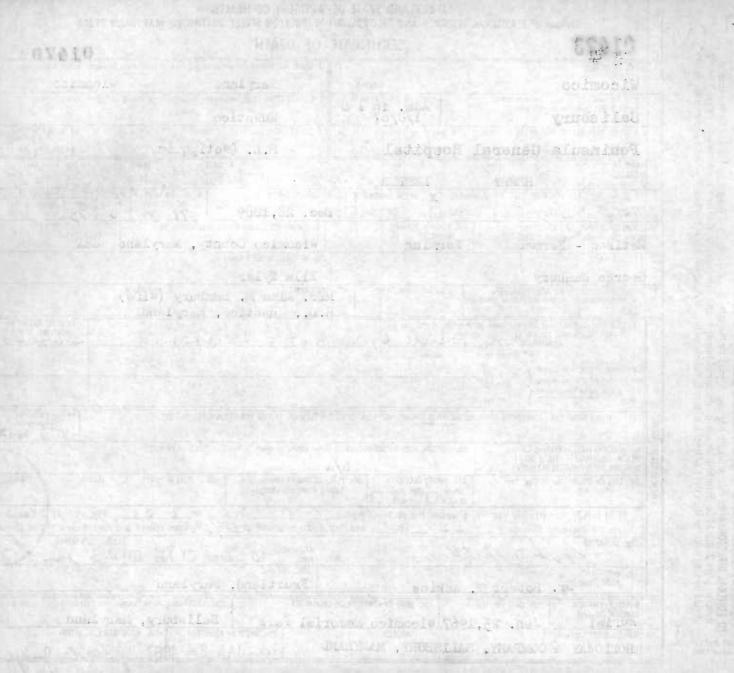
ARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY b. COUNTY Wicomico MARYLAND Maryland Wicomico b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and giva neerast town) write RURAL and give nearest town) Salisbury Salisbury d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) d. STREET ADDRESS a. IS RESIDENCE ON A FARM? YES NO W Kavwood Kaywood 3. NAME OF Middle Last 4. DATE Month Day DECEASED OF (Typa or print) DEATH SAMUET SOMERS GUNBY 6. COLOR OR RACE 7. MARRIED NEVER MARRIED IF UNDER 24 HRS 9. AGE (In years | IF UNDER 1 YEAR B. DATE OF BIRTH Male last birthday) Months Dave WIDOWED DIVORCED TO 10a. USUAL OCCUPATION (Giva kind of work BIRTHPLACE (State or foreign country) 10b, KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY? dona during most of working life, even if retired) Electrician Repairman Maryland
14. MOTHER'S MAIDEN NAME U.S.A. 13. FATHER'S NAME Samuel S. Gunby

15. WAS DECEASED EYER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. Lizzie Perdue 17. INFORMANT Address (Yes, no, or unkown) | (Ifyas give wer or detes of service) Salisbury, Miss Clara C. 18. CAUSE OF DEATH [Enter only one cause par little for (a), (b), end (c),) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Office alc DUE TO Conditions, if any, which gave risa to immadiata causa DUE TO (a), stating the underlying (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 19, WAS AUTOPSY CERTIFICATION PERFORMED? NO 20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURED, (Enter nature of injury in Part I or Pert II of itam 18.) PRIMARY | or CONTRIBUTING | S 0 CAUSE OF DEATH. MEDICAL 20c. TIME OF INJURY Month, Dev. Year 20d. INJURY OCCURRED 2De. PLACE OF INJURY (Home, ferm. 20f. (City or town) (State) While factory, street, office bldg., etc.) Not While at work at work 21. I certify that I took charge of the remains described above, held an Autopsy Inspection and in my opinion death resulted from: Matural causes Accident Suicide Homicide Undetermined manner DIRE CHIEF MEDICAL EXAMINER ACTUAL please executed should be in Health or its de ASSISTANT MEDICAL EXAMINER DATE SIGNED SIGNATURA DEPUTY MEDICAL EXAMINER 1-20-67 EXAMINER'S NAME (Typa) Address (Street, city, town, or county) PATE THER OYER 22a. BURIAL, CREMATION, 22b. 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or country) (State) REMOVAL (Spacify) Salisbury, Maryland Burial Parsons Cemetery 24a. REC'D BY REGISTRAR VR A15ME 5M 1/62

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH burial, cremation, or removol, and in any event, within 72 hours ofter death. OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours ofter death and completely filled in by the funeral remove carbon papers. Pages 1 and 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) 1. PLACE OF DEATH Wicomico o. STATE MARYLAND CITY OR TOWN (If outside corporate limits, write\_RURAL and give nearest town) c. LENGTH OF STAY IN 1b If outside corporate limits, write RURAL Salisbury IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS Peninsula General Hospital YES NO X the ottending physicion and completely fisit permit. Then please remove carbon 3. NAME OF 4. DATE Year Dov DECEASED ANUARY DEATH (Type or print) S. SEX 6. COLOR OR RACE DATE OF NEVER MARRIED birthdoy) Doys Months Hours Min. WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 12. CITIZEN OF WHAT 10b. KIND OF BUSINESS OR (County & Stote, or foreign country) during most of working life, even if retired) 13. FATHER'S NAME 14. MOTHER'S WAS DECEASED EVER IN U.S. ARMED FORCES? INFORMAN (Yes, no, or unknown) (If yes give wor or dates of service) 6210A INTERVAL BETWEEN ONSET AND DEATH CAUSE OF DEATH (Enter only one cause per line for burial-tronsit PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) signed by Poge 4 may be retained by the hospital or attending physicion. DUE TO Conditions, if ony, which gove (b) rise to immediate couse (o) DUE TO stoting the underlying couse detached for use os the te Dept. of Heolth prior to this certificate has been last. 19. WAS AUTOPS)
PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NO C 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) director, page 3 should be detache should be filed with the State Dept. 20e. PLACE OF INJURY (Home, form, (Stote) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED (City or town) (County) foctory, street, office bldg., etc.) Hour o.m. Not While ot work of work TO FUNERAL DIRECTOR: After 21. I certify that (1) (this haspital) attended the deceased fram 120 M, fram causes and an the date stafed above. saw the deceased alive on and that death accurred at 22b. DATE SIGNED 22o. SIGNATURE STAFF DIRECTOR PHYS. PHYS. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) BURIAL CREMATION 23h DATE THEREO NAME OF CEMETERY OR CREMATORY LOCATION (City or Town) (County) (Stote MEMOVAL (Specify) 2So. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE VR A15 (4) 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 01473 CERTIFICATE OF DEATH The law requires that the deoth certificate be executed within 24 hours after deoth death puo 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 1. PLACE OF DEATH o. COUNTY Wicomico COUNTY a. STATE Wicomico Maryland MARYLAND event, within 72 hours ofter completely filled in by the love corbon papers. Pages b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn)
Salisbury Adm. in 1 bd c. CITY OR TOWN (If outside carporate limits, write RURAL and give neorest tawn) Quantico remove corbon papers. d. STREET ADDRESS e. IS RESIDENCE d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) ON A FARM? (Wetipquin) Peninsula General Hospital R.D. YES NO 3 NAME OF First 4. DATE Year Last Day DECEASED 19 6 HENRY LESTER DEATH (Type or print) IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE X B. DATE OF BIRTH AGE (In years 7. MARRIED NEVER MARRIED last birthday) Manths Days Hours Dec. 28,1889 and in any WIDOWED DIVORCED 25 0 and 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) 10o, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR COUNTRY? attending physician o permit. Then please during most of working life, even if retired)
Retired - Farmer INDUSTRY Wicomico County, Maryland Farming 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME removol, Ella Tyler George Hambury IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. Mrs. Alma M. Hambury (Waddress) permit. (Yes, no, or unknown) (If yes give war or dates af service cremation, ar No R.D. Quantico, Maryland INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) 2 ONSET AND DEATH buriol-transit PART I. DEATH WAS CAUSED BY: -cu Kenia IMMEDIATE CAUSE (o) signed by Page 4 may be retained by the hospital or attending physicion. DUF TO buriol, Canditians, if any, which gave rise to immediate cause (a), DUE TO stoting the underlying cause peen prior to for use as the last. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) FUNERAL DIRECTOR: After this certificate hos of Health NO Z 205. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 1B.) 20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH detached N/A (IF EITHER, NOTIFY MEDICAL EXAMINER) with the Stote Dept. 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Day, Year Hour a.m. factory, street, affice bldg., etc.) Not While at wark ot wark , 196 2, that (I) (we) last 21. I certify that (1) (this haspital) attended the deceased fram. 19 6 2 ta 3 should saw the deceased alive an 1-22 1967, and that death accurred at 450/1 M, fram causes and an the date stated above. 22b. DATE SIGNED 22a. SIGNATUK Kens V M.D. DIRECTOR PHYS. PHYS. director, poge should be filed 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Dr. Fruitland, Maryland Robert T. Adkins 23d. LOCATION (City or Town) 23c. NAME OF CEMETERY OR CREMATORY 23a. **BURIAL, CREMATION** 23b. DATE THEREOF (County) (Stote) REMOVAL (Specify) Salisbury, Maryland 967 Wicomico Memorial Park 9 2Sb. REGISTRAR'S SIGNATURE 2Sa. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15 (4) HOLLOWAY & COMPANY, SALISBURY, MARYLAND 1967



19-7 7. V. I. I. . 612 014 

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 OF DEATH CERTIFICATE requires that the death certificate be executed within 24 haurs after death 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 1. PLACE OF DEATH deal d. COUNTY Wicomico a. STATE b. COUNTY MARYLAND Wicomico any event, within 72 haurs after b. CITY OR TOWN (If autside carparate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) write RURAL and give nearest tawn) Salisbury Salisbury d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? completely filled in Peninsula General Hospital Catherine NO R 3. NAME OF Middle 4. DATE Day Last Year DECEASED 19 6 (Type ar print) DEATH S. SEX 6. COLOR OR RACE DATE OF BIRTH AGE (In years IF UNDER I YEAR IF UNDER 24 HRS 7. MARRIED NEVER MARRIED last birthday) Manths Days Haurs WIDOWED DIVORCED 28/1899 Colored and 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 10a, USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & State, or foreign country) during mast of warking life, even if retired) COUNTRY? INDUSTRY Maryland Labor 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME crematian, ar remava Ross Harmon Ida Hutt IS. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, ar unknawn) (If yes give war ar dates af service) 16. SOCIAL SECURITY NO. 17. INFORMANT Address No Harmon 226 Cathrine St. NJERVAL JETWEEN ONSEJ ANO, DEATH 1B. CAUSE OF DEATH (Enter anly ane cause per line far (a), (b)
PART I. DEATH WAS CAUSED BY: burial-transit IMMEDIATE CAUSE (a) signed by DUE TO burial, Canditians, if any, which gave rise ta immediate cause (a), DUE TO stating the underlying cause Page 4 may be retained by the haspital ar attending priar ta has been as the last. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINA far use Dept. af Health YES NO O FUNERAL DIRECTOR: After this certificate DESCRIBE HOW INNIRY OCCURRED (Enter nature of in 20g. ACCIDENT WAS UNDERLYING iun in Part | ar Part OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE Of INJURY (Name, farm, factory, street, affice odg., etc.) 20d. INJURY OCCURRED (City ar tawn) (County) (State) 20f. 20c. TIME OF INJURY Manth, Day, Year Haur a.m. with the State at wark 1960 21. I certify that (1) (this haspital) attended the deceased fram. 1961, that (I) (we) last and that death accurred at 5 23/4 M from causes and an the date stated abave. saw the deceased alive an. 1961 22a. SIGNATURE 22b DATE SIGNED **ATTENDING** DIRECTOR PHYS. M.D. director, page shauld be filed 22da ADDRESS 22c. PHYSICIAN'S NAME (Type) 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (State) REMOVAL (Specify) Salisbury Acres Green 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR 2Sa. REC'D BY REGISTRAR tianles VR A15 (4) 20 M 1/66 DATE

Agenteo Vinds11n8 Peningald General Houghted 20 Carried by Charles I will be be to the total the time of the time of 

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01476	CERTIFICATE	OF DEATH		01473
1. PLACE OF DEATH				n: Residence befare admission) /
O. COUNTY Wicomico	MARYLAND	O. STATE	b. COUNT	1000 more ret
b. CITY OR TOWN (If outside corporate limits,	c. LENGTH OF STAY IN 1b		carporote limits, write RURA	ond give peorest town)
write RURAL and give nearest town) Salisbury	C. ELNOW OF SIM IN 10	2		227
		125RL	i /V	d. D. d
d. NAME OF HOSPITAL OR INSTITUTION (If not in	hospitol, give street oddress)	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?
Peninsula Genera	l Hospital	VINE	ST	YES NO 🔂
3. NAME OF First	Middle	Lost 4.	DATE Month	Day Year
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	MARRIED NEVER MARRIED	B. DATE OF BIRTH	9. AGE (In years   last birthdoy)	IF UNDER 1 YEAR   IF UNDER 24 HRS.
r	WIDOWED DIVORCED	DEC. 11 19	18 last birthdoy)	Months Doys Hours Min.
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ANGUS TODE		HELEN		
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1B. CAUSE OF DEATH (Enter only one cause		1		INTERVAL BETWEEN
PART I. DEATH WAS CAUSED BY:	motostatio (occe	usua) tone	una or Diam.	ONSET AND DEATH
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≥ 20o. ACCIDENT WAS UNDERLYING □	20b. DESCRIBE HOW INJURY OCCURRED.	(Enter noture of injury in Part	I ar Part II of item 1B.)	
OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
	20d. INJURY OCCURRED 20e. PLAG	CE OF INJURY (Hame, farm,	20f. (City ar tawn)	(County) (State)
Hour a.m.	While Not While foct	ory, street, affice bldg., etc.)		(2.2.4)
p.m. 17	at work U at wark U	All a sale	5 1	- 17
21. I certify that (I) (this hospit	al) attended the deceased from_	Mig. , 196		, 19 <u>_6 (,</u> that (1) ( <del>we)</del> la:
saw the deceased alive an	196/, and that	t death occurred at	M, from causes a	nd an the date stated above
22a. SIGNATURE		ATTENDING A MED	). STAFF	22b. DATE SIGNED
Resusa	Marchar M.	D. PHYS. LA DIRI	ECTOR PHYS.	1119161
22c. PHYSICIAN'S RULUS	S GARDIERTA	22d. ADDRESS	AL CENTE	ER. SALisbury Md
23o. BURIAL CREMATION. 23b. DATE THERE	OF 23c. NAME OF CEMETERY OR-	FREMATORY I	23d. LOCATION (City or Tow	n) (County) (Stote)
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10 URIAL 1491		2Sa. REC'D BY	DECISTRAD LOSS DEC	ISTRAR'S SIGNATURE
24. FUNERAL DIRECTOR	ADDRESS A- V	A 67		(Charles Judge
1+226 09.12C	work Hellen!	DATE A	N 23 1967	1- 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours ofter death.

Poge 4 moy be retained by the haspitol or attending physicion.

VR A15 (4)

**TO FUNERAL DIRECTOR:** After this cerificate hos been signed by the attending physicion and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corbon popers. Pages 1 and should be filed with the State Dept. af Health priar to burial, cremation, or removal, and may be went, within 72 hours ofter deat

4 17 Approved to the second second mile take Covering me to make who -2370 Fo states were been and being Lewis III amania 10/2/11 II The second of the s The transfer of the state of th

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral death. hours after death. PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) b. COUNTY by the f. Pages 1 urs after Wicomiao Wicomico Maryland MARYLANO b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL end give nearest town) hours .= Salisbury Parsonsburg remove carbon papers.
In any event, within 72 ho d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e. IS RESIDENCE ON A FARM? d. STREET AODRESS Peninsula General Hospital NO (Ocean City Road) YES executed within 3. NAME OF Middle Last DATE Month DECEASED JOHN (Type or print) WARREN HENSZEY 1967 DEATH January 5. SEX 6. COLOR OR RACE DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. 7. MARRIED NEVER MARRIED last birthday) Months Hours Male White Jan. 28. 1920 WIDOWED I DIVORCED 46 = 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 12. CITIZEN OF WHAT 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) physician ease pe COUNTRY? and USA Philadelphia. Pa. Construction Co. Accountant removal, 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME attending phermit. Their Rowena Wilhite W. Harland Henszey 15. WAS DECEASED EVER IN U.S. ARMED FORCES? Mrs.Eugenia G. Henszey Addressife) 16. SOCIAL SECURITY NO. been signed by the atten the burial-transit permit. It to burial, cremation, or death (Yes. no. or unkown) (If yes give war or dates of service) 190-18-8429 War II Yes R.D. #2. Parsonsburg, Md. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND OFATH PHYSICIAN: The law requires that the the hospital or attending physician. PART I. DEATH WAS CAUSED BY: 01785 IMMEDIATE CAUSE (a DUE TO Conditions, if any, which (b) gave rise to immediate **OUE TO** cause (a), stating the as th underlying cause last, TO FUNERAL DIRECTOR. After this certificate has director, page 3 should be detached for use as should be filed with the State Dept. of Health prior (c) CERTIFICATION WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? YES X NO 20a. ACCIDENT WAS UNDERLYING I DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) OR CONTRIBUTING () CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20c. TIME OF INJURY Month, Oav. Year 20d. INJURY OCCURRED 20f. (City or town) (County) (State) Hour a.m. While at work Not While be retained by OR ATTENDING at work 21. I certify that (1) (this hospital) attended the deceased from 194 196/ and that death occurred at 6:35M, from the causes and on the date stated above. saw the deceased alive on 22b. DATE SIGNED 22a. SIGNATURE-ATTENOING PHYS. STAFF PHYS. Page 4 may I DIRECTOR M.O. 22d. ADDRESS PHYSICIAN'S NAME (Type) Dr. Nevins W. Center, Salisbury, Md. Medical Todd 23d. LOCATION (City, town or county) (State) BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY REMOVAL (Specify) Jan. 18. 1967 Wicomico Memorial Park Salisbury, Maryland Burial
24. FUNERAL DIRECTOR REC'O BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE **ADDRESS** 25a. Climas HOLLOWAY & COMPANY, SALISBURY, MARYLAND VR A15 (4) 15M 4-64

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CHAPTER BUTLES THE 20TH OF THE PERSON

(M)	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
death.	01478 CERTIFICATE OF DEATH 01475
מונפו מפונפו מפונפו מפונפו מונפו מ	PLACE OF DEATH a. COUNTY  Wicomico  MARYLAND  2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) b. COUNTY b. COUNTY  New York
	b. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) Salisbury  C. LENGTH DF STAY IN 1b Rew York City
	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  d. STREET ADDRESS  e. IS RESIDENCE ON A FARM?
=	Wicomico Nursing Home
5	DECEASED (Type or print) ALICE (NWI) HIEBENDAHL DEATH Sanuary 17 19 67
5	SEX   6. COLOR OR RACE   7. MARRIED   NEVER MARRIED   8. DATE OF BIRTH   9. AGE (In years list birthday)   Mopths   Days   Hours   Min.    Female   White   WIDOWED   June 28, 1882   84 yrs.   6 19
11 d	Da. USUAL OCCUPATION (Give kind of work done   10b. KIND DF BUSINESS DR   11. BIRTHPLACE (County & State, or foreign country)   12. CITIZEN OF WHAT INDUSTRY
1	None - New York City, N. Y. USA 3. FATHER'S NAME 14. MOTHER'S MAIDEN NAME
	(Unk.) Myer (Unk.)
(	15. WAS DECEASED EVER INU.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Mr. William Hiebendahl (Son)  No Upper Feery Road, R.D., Salisbury, Md.
	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a)  DUE TD  Conditions, If any, which gave rise to immediate  (b)  Conditions of the con
CERTIFICATION	cause (a), stating the UE TO underlying cause last.  (c)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)  19. WAS AUTOPSY PERFORMED?  YES NO 120a. ACCIDENT WAS UNDERLYING 1 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 11 of Item 1B.)
110	AND THE RESIDENCE OF THE PARTY
MEDICAL	20c. TIME OF INJURY Month, Day, Year   20d. INJURY OCCURRED   20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   4 work   20f. (City or town)   (State)   4 work   20f. (City or town)   (State)   20f. (City or town)   (State)   20f. (City or town)   20f. (City or t
	21. I certify that (I) (this hospital) attended the deceased from 12-3, 1965, to 1-17, 1967, that (I) (we) last
	saw the deceased alive on Jan. 17 19 67, and that death occurred at 1:21, from the causes and on the date stated above 22a. SIGNATURE  M.D. ATTENDING MED. 22b. DATE SIGNED  M.D. PHYS. DIRECTOR PHYS. Jan. /8 /1967
	22c. PHYSICIAN'S NAME (Type) Dr. John T. Bulkeley 22d. ADDRESS Salisbury, Maryland
2	Ba. BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. 10CATION (City, town or county) (State) REMOVAL (Specify)
1	44. FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR'S SIGNATURE HOLLOWAY & COMPANY SALTSPILLY MARYLAND
=	DATE JAN 20 1967 generally finds

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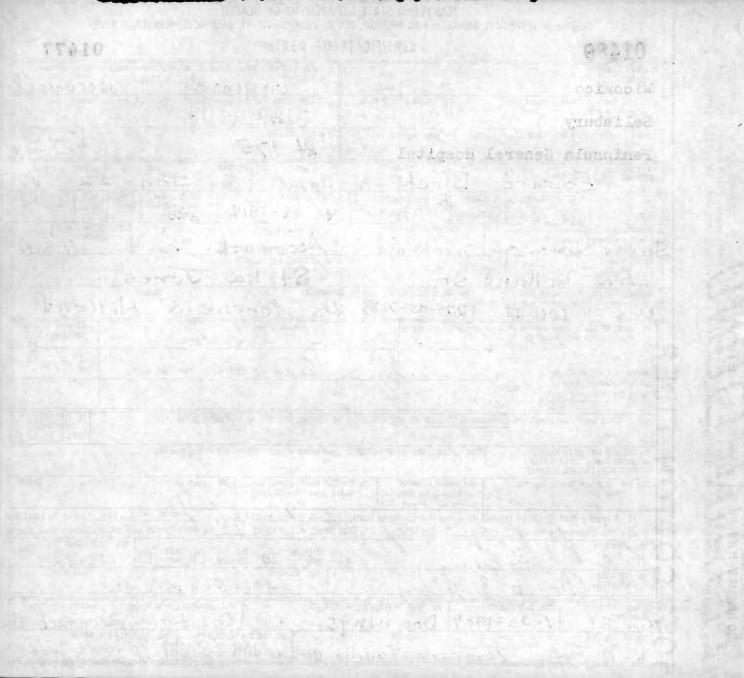
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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Page 4	rect		230	BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREO				3d. LOCATION (City or To		(Sfote)
00	OPT	00		Burial	Jan. 18,	1967   Parsons Cen	neterv		Balisbury, 1	Marytand	
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 01480 01477 CV certificate be executed within 24 haurs after death. death. and 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) by the funeral Wicomico b. COUNTY o. STATE signed by the attending physician and campletely filled in by the fun burial-transit permit. Then please remave carban papers. Pages 1 burial, crematian, ar remaval, and in any event, within 72 haurs after MARYLAND (If autside carparate limits, write RURAL and give nearest tawn) b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN write RURAL and give nearest tawn) Watsville Salisbury d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? YES 🗍 NO X Peninsula General Hospital 3. NAME OF Last DATE Manth Year DECEASED 1967 2 2 Jan (Type or print) DEATH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED last birthday) Manths Days Hours MOU WIDOWED DIVORCED 12. CITIZEN OF WHAT 10g. USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (Caunty & State, or foreign country) during most of working life even if retired) INDUSTRY COUNTRY? Service 13. FATHER'S NAME or hance 14. MOTHER'S MAIDEN NAME 16. SOCIAL SECURITY NO 17. INFORMANT (Yes, no, or unknown) (If yes give war or dotes of service) 229-05-7183 Holland INTERVAL BETWEEN ONSEL AND DEATH CAUSE OF DEATH (Enter only one cause per liber for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) be retained by the haspital ar attending physician. DUE TO Conditions, if ony, which gove rise to immediate couse (a), DUE TO stating the underlying couse TO FUNERAL DIRECTOR: After this certificate has been detached far use as the e Dept. af Health priar ta PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? CERTIFICATION NO YES 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) be detached State Dept. o (City on town) TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (County) (State) factory, street, affice bldg., etc.) Hour o.m. Not While While at wark 21. I certify that (1) (this hospital) attended the deceased fram. director, page 3 shauld shauld be filed with the Maram causes and an the date stated above. saw the deceased alive a and that death accurred at 22a. SIGNATURE 22b. DATE SIGNED ATTENDING X M.D. PHYS DIRECTOR PHYS PHYSICIAN'S 22d. ADDRESS 22c. 5 Ba NAME (Type) 23c. NAME OF CEMETERY, OR CREMATORY 23b. DATE THEREOF 23d. LOCATION (City or Town) (County) (Stote) 23a. BURIAL, CREMATION, Bur a Oak Hall-Accomac ownings 25b. REGISTRAR'S SIGNATUR 2Sq. REC'D BY REGISTRAR FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 DATE JAN emperancoville Va



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE 01478 HEALTH DEPT. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY o. STATE b. COUNTY delay is and 3 ta d f death. Wicomico MARYLAND Maryland Department b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b. Baltimore Salisbury d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d STREET ADDRESS e. IS RESIDENCE ON A FARM? 3/ day hours alang with farm Give Pages 1, Peninsula General Hospital Shelton Avenue ate YES NO TXC with the Sto within 72 h 3. NAME OF Middle Lost DATE Month Doy Year DECEASED ANNA MARY HOMER 1967 January (Type or print) DEATH B. DATE OF BIRTH AGE (In years IF UNOER IF UNOER 24 HRS. S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIEO lost birthdoy) Months Days Hours in Item 18. June 6. 1910 WIDOWED X DIVORCED haurs Female White event 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired)

Retired - Waitress INDUSTRY COUNTRY? Pennsylvania in any page Examiner 13. FATHER'S NAME 14 MOTHER'S MAJOEN NAME pencil executed within Franklin Edison Riley Luella Cooper and Mrs. Brady Franklin (Daughter) 107 Clemwood Avenue, Salisbury, WAS OFCEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO rd "pending" in Chief Medical E permit. Yes, no, or unknown) (If yes give wor or dotes of service) remayal, No 166-16-2789 Maryland INTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per line for (o), (b) gnd (c).) burial-transit OMSET AND GEATH PART I OFATH WAS CAUSED BY ar IMMEDIATE CAUSE (o) shauld the ward crematian, OUF TO Conditions, if ony, which gove (b) rise to immediate couse (a). OUF TO certificate stoting the underlying couse ficate, writing the = burial, PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) WAS AUTOPSY PERFORMEO? CERTIFICATION please execute the certificate. YES 30 NO pe ta 20o. EXTERNAL CAUSE WAS prigr 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 3 should PRIMARY CONTRIBUTING C MEDICAL EXAMINER: CAUSE OF DEATH MEDICAL agent, 20c. TIME OF INJURY Month, Dov. Year 20d. INJURY OCCURREO 20e, PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour o.m. While Not While foctory, street, office bldg., etc.) FUNERAL DIRECTOR: Page ot work ot work 21. I certify that I book charge of the remains described above, held an Autapsy X Inquiry x Inspection and in my apinian the funeral director. death resulted from: Natural causes Accident Suicide Homicide Undetermined manner be retained CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE O DEPUTY 0 Dr. Earl L. Royer DEPUTY MEDICAL EXAMINER EXAMINER'S January Health NAME (Type) Salisbury, Maryland duress (Sireet, city, town, or county) 409 Camden Ave. 23c. NAME OF CEMETERY OR CREMATORY 23o. BURIAL CREMATION. 23b. OATE THEREOF 23d. LOCATION (City or Town) (County) (Stote) 0 REMOVAL (Specify)
Burial Baltimore National Catonsville, Maryland Jan. 12,1967 Cemetery 2Sb. REGISTRAR'S SIGNATURE AODRESS 24. FUNERAL DIRECTOR 2So. REC'D BY REGISTRAR Miarles VR A15ME (5) HOLLOWAY & COMPANY, SALISBURY, MARYLAND

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 01479 01482 by the funeral Pages 1 and 2 naurs after death, requires that the death certificate be executed within 24 haurs after death. 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 1. PLACE OF DEATH a. COUNTY Wicomico a. STATE b. COUNTY Maryland Wicomico MARYLAND c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest tawn) b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn)
Salisbury c. LENGTH OF STAY IN 1b haurs Salisbury papers. hin 72 ha d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? .⊑ campletely filled in nove carban paper YES NO TO Peninsula General Hospital 511 Hammond Street Day 3. NAME OF Last DATE Manth Year event, wit DECEASED 196 DEATH EDWARD MACE DMPS (Type or print) IF UNDER 24 HRS. IFUNDER 1 YEAR 8. DATE OF BIRTH AGE (In years 6. COLOR OR RACE NEVER MARRIED 130 7 MARRIED last birthday) Months Days Haurs Jan. 28, 1967 DIVORCED WIDOWED White 11. BIRTHPLACE (County & State, or fareign country) 12. CITIZEN OF WHAT 10b. KIND OF BUSINESS OR 10a. USUAL OCCUPATION (Give kind af wark dane COUNTRY? during most of working life, even if retired) INDUSTRY physician Salisbury, Maryland USA none 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME crematian, ar remaval, Billy Conn Jones Eileen Louise Gordy 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ((If yes give war ar dates af service) 17. INFORMANT 16. SOCIAL SECURITY NO. Address & Mrs. Billy C. Jones (Parents) Hammond St., Salisbury, Md. INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter anly one couse per line for (a), (b), and (c).) signed by the burial-transit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) Page 4 may be retained by the hospital or attending physician. DUE TO burial Canditions, if any, which gove (b) rise to immediate cause (a), **DUE TO** far use os the t Heolth prior tab stating the underlying couse O FUNERAL DIRECTOR: After this certificate has been PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? CERTIFICATION NO 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II af item 18.) 20g. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH df. detached N/A (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City ar tawn) (County) (State) 20c. TIME OF INJURY Month, Day, Year factory, street, office bldg., etc.) Not While Hour o.m. 19 at work ot work pe , 1967, that (I) (we) last e deceased fram\_\_\_\_\_\_\_, 19\_\_\_\_\_, ta\_\_\_\_\_\_, 19\_6\_/, that (1) (we) last \_\_\_\_\_\_\_\_, and that death accurred at \_\_\_\_\_\_\_, M, fram causes and an the date stated abave. 21. I certify that (I) (this haspital) attended the deceased fram. director, page 3 shauld shauld be filed with the saw the deceased alive an. 22b. DATE SIGNED 22o. SIGNATURE ATTENDING MED. DIRECTOR STAFF PHYS. M.D. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Salisbury, Maryland William C. Morgan 23d. LOCATION (City or Town) (Stote) 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY REMOVAL (Specify)
Burial Salisbury, Maryland 1967 Wicomico Memorial Park 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR HOLLOWAY & COMPANY. SALISBURY. MARYLAND VR A15 (4) 20 M 1/66 DATE

MARYLAND STATE DEPARTMENT OF HEALTH

01480

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 01483 CERTIFICATE OF DEATH

	1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission)						
	Wicomico	MARYLAND	O. STATE MARYLAND SOMERSET						
	b. CITY OR TOWN (If outside corporate limits		c. CITY OR TOWN (If outside corporate limits, write RURAL and	give neorest town)					
	write RURAL ond give neorest town) Salisbury		PRINCESS ANNE	19.2					
	d. NAME OF HOSPITAL OR INSTITUTION (If no	t in hospitol, give street oddress)	d. STREET ADDRESS e. IS RESIDE						
9	Peninsula Gener	al Hospital		ON A FARM? YES X NO					
	3. NAME OF Fire		Lost 4. DATE Month	Doy Year					
	DECEASED (Type or print) Edor	14	EMP DEATH JANUAR	V 10 1967					
	S. SEX 6. COVOR OR RACE	7. MARRIED NEVER MARRIED	8. DATE OF BIRTH 9. AGE (In years IF UN last birthday) Mont	ths Dovs Hours Min.					
	male white	WIDOWED DIVORCED	SEPT.8, 1894 72 yrs.	ths Doys Hours Min.					
	10o. USUAL OCCUPATION (Give kind of work done	10b. KIND OF BUSINESS OR	11. BIRTHPLACE (County & Stote, or foreign country)	2. CITIZEN OF WHAT					
	during most of working life, even if retired) NURSERYMAN	NURSERY	CONFLUENCE. PENN.	2. CITIZEN OF WHAT COUNTRY?					
	13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME						
ı	GEORGE KEMP		EFFIE L. BISHOFF						
9	IS. WAS DECEASED EVER IN U.S. ARMED FORCES?		INFORMANT Address						
	(Tes, no, or unknown) (IT yes give wor or dotes of	Yes, no, or unknown) (If yes give wor or dotes of service)  ROBERT KEMP - PRINCESS ANNE MD.							
	1B. CAUSE OF DEATH (Enter only one cou-	se per line for (a) (b), ond (c).)		INTERVAL BETWEEN					
	PART I. DEATH WAS CAUSED BY:	PART I. DEATH WAS CAUSED BY:							
	1/1///	420./ DUE TO							
	Conditions, if ony, which gove								
	stoting the underlying couse DUE	rise to immediate couse (o), stoting the underlying couse  DUE TO							
	lost.	(c) ( arone and	luseluse						
	PART II. OTHER SIGNIFICANT CONDITIONS CO	ONTRIBUTING TO DEATH BUT, NOT RELATED TO	THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0)	19. WAS AUTOPSY PERFORMED?					
	200. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING CAUSE OF DEATH OF CONTRIBUTING CAUSE OF DEATH OF CONTRIBUTING CAUSE OF DEATH			YES NO					
	20o. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING CAUSE OF DEATH	20b. DESCRIBE HOW INJURY OCCURRED.	(Enter noture of injury in Part I ar Part II of item 1B.)						
	(II LITTLE, NOTITE I MEDICAL LAAMINEN)								
	20c. TIME OF INJURY Month, Doy, Year Hour o.m.		(CE OF INJURY (Home, form, tory, street, office bldg., etc.)	(County) (Stote)					
	p.m. 19	ot work ot work							
	21. I certify that (I) (this has	21. I certify that (I) (this haspital) attended the deceased fram /-/2, 1967 ta /- 20-, 1967, that (I) (we) last							
		saw the deceased alive an 1-20-1967, and that death accurred at M, fram causes and an the date stated above.							
H	220. SIGNATURE	ATTENDING TO MED. STAFF							
	22c. PHYSICIAN'S	w prefiger M.	D. PHYS. DIRECTOR L. PHYS. L. 22d. ADDRESS	1 81-61					
	NAME (Type)								
-	23o. BURIAL, CREMATION, 23b. DATE THE	REOF 23c. NAME OF CEMETERY OR	CREMATORY 23d. LOCATION (City or Town)	(County) (Stote)					
	BURNOYA (Specify) 1/23/	1 = = = = = = = = = = = = = = = = = = =	DRINGEGG A	NNE, MD.					
)	24. FUNERAL DIRECTOR	ADDRESS ADDRESS	ULIO - UPHVETNEY	RX6 SIGNATURE O					
1	LEVEN R. WILSON		MD. DATE JAN 24 1967	warley judge					

DATE

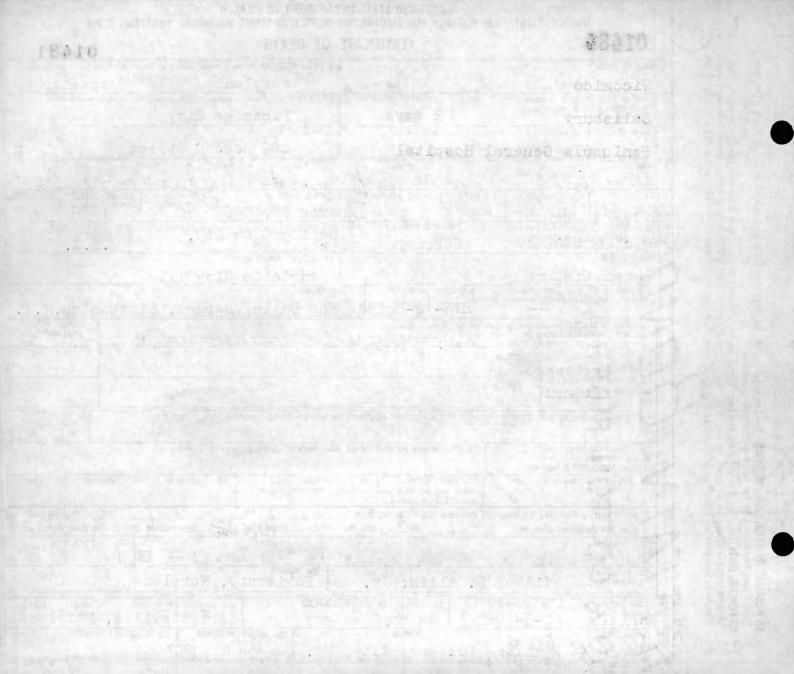
VR A15 (4) 20 M 1/66

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shauld be detached far use as the burial-transit permit. They please remove carban papers. Pages 1 and Z shauld be filed with the State Dept. of Health priar ta burial, crematian, ar remayal, and in any event, within 72 haurs after death.

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death.

Page 4 may be retained by the haspital ar attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 01484 CERTIFICATE OF DEATH death. executed within 24 haurs after death and campletely filled in by the funeral remave carban papers. Pages I and 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) Wicomico o. STATE b. COUNTY Worcester Maryland MARYLAND in any event, within 72 haurs after b. CITY DR TDWN (If outside corporate limits, write RURAL and give nearest tawn) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b 2 days Pocomoke City Salisbury d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS IS RESIDENCE DN A FARM? 406 Second Street Peninsula General Hospital YES NO TX 3. NAME OF Middle 4. DATE First lost Doy Year DECEASED OLGA nual 196 (Type or print) DEATH 6. COLOR OR RACE KGE (In years S. SEX DATE OF BIRTH 7. MARRIED NEVER MARRIED last birthdoy) Months Dovs Hours . 1896 White March WIDOWED X DIVORCED Oa LISUAL OCCUPATION (Give kind of work done 10b. KIND DF BUSINESS OR BIRTHPLACE (County & Stote, or foreign country)
TTIOTO COUNTY 12. CITIZEN OF WHAT pe COUNTRY? during most of working life even if retired) Registered Nurse Nursing requires that the death certificate Maryland 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME the attending physisit permit. Then to remava Henrietta Clayville Jeremiah Horn 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, go, or unknown) (If yes give wor or dotes of service) 16. SOCIAL SECURITY ND. 17. INFORMANT 0 213-12-2823A Mrs Daniel Bergen, Binghamton, N.Y. INTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART 1. DEATH WAS CAUSED BY: burial-transit ONSET AND DEATH IMMEDIATE CAUSE (o) signed by Page 4 may be retained by the haspital ar attending physician. DUE TO burial, Conditions, if ony, which gave rise to immediate couse (a). DUE TO stoting the underlying couse as the this certificate has been last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) WAS AUTOPSY PERFORMED? far use Health p NO 205. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) directar, page 3 shauld be detache shauld be filed with the State Dept. (City or town) 20c. TIME OF INJURY Month, Day, Yeor 20d, INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (County) (Stote) Hour o.m. While Not While foctory, street, office bldg., etc.) ot work ot work O FUNERAL DIRECTOR: After 196 /that (I) [we) last 21. I certify that (1) (this haspital) attended the deceased fram. and that death accurred at 332M, from causes and on the date stated above. saw the deceased alive an 22b. DATE SIGNED 220. SIGNATURE ATTENDING MED. DIRECTOR STAFF PHYS. M.D. 22d. ADDRESS 22c. PHYSICIAN'S Salisbury, Maryland Ellis Wilbur R. NAME (Type) 23c. NAME OF CEMETERY OF CREMATORY 23d. LOCATION (City or Town) 23b. DATE THEREOF (County) 23o. BURIAL, CREMATION, (Stote) Jarrettsville, Maryland 1-5-1967 Salem Cemetery RAL DIRECTOR ADDRESS 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE DATE JAN 6 1967 Pocomoke City, Md.



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 01485 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) I. PLACE OF DEATH o. COUNTY
Wicomico b. COUNTY MARYLAND c. LENGTH OF STAY IN 16 b. CITY OR TOWN (If outside corporate limits, c. CITY OR TOWN (If outside/corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) Salisbury d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address e. IS RESIDENCE ON A FARM? d. STREET ADDRESS Peninsula General Hospita YES NO 3. NAME OF 4. DATE Month Dov Year Middle Lost OF DEATH DECEASED (Type or print) IF UNDER 1 YEAR IF UNDER 24 HRS 9. AGE (In years 6. COLOR OR RACE 7. MARRIED NEVER MARRIED olast birthdoy) Months Hours Doys WIDOWED DIVORCED 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) during most of working life, even if retired) INDUSTRY COUNTRY 2 14. MOTHER'S MAIDEN NAME FATHER'S NAME nown 17. INFORMANT WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO (Yes, no or upknown) (If yes give wor or dates of service) INTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate couse (a). DUE TO stoting the underlying couse 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NO YES 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (Stote) 20e. PLACE OF INJURY (Home, form, (City or town) (County) 20d. INJURY OCCURRED 20c. TIME OF INJURY Month, Doy, Year foctory, street, office bldg., etc.) Hour o.m. Not While 19 ot work a 1962, that (1) (we) last 21. I certify that (1) (this haspital) attended the deceased fram. and that death accurred at M. fram causes and an the date stated above. saw the deceased alive an 1900 22b. DATE SIGNED 22o. SIGNATURE ATTENDING

be executed within 24 haurs after death funeral one burial, cremotian, or removal, and in any event, within 72 haurs after completely filled in by the ove carban popers. Pages remove carban physicion of certificote offending p requires that the death signed by the buriol-tronsit p Poge 4 may be retoined by the hospital or attending Health prior to FUNERAL DIRECTOR: After this certificate hos been or use os the State Dept. of director, page 3 should be should be filed with the Stat 2

S. SEX

VR A15 (4) 20 M 1/66

23o. BURIAL, CREMATION 23b. DATE THEREOF REMOVAL (Specify) 24. FUNERAL DIRECTOR

22c. PHYSICIAN'S NAME (Type)

23c. NAME OF CEMETERY OR CREMATORY

PHYS.

ADDRESS 22d.

M.D.

2So. REC'D BY REGISTRAR

DIRECTOR

23d-LOCATION (City or Town)

PHYS

25b. REGISTRAR'S SIGNATURE Charel

(Stote)

88511 \*\*\* 0011000 TOTAL SECTION Latinate General Rockiel

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 01486 01483 requires that the death certificate be executed within 24 haurs after death. death and and campletely filled in by the funeral remave carban papers. Pages 1 and in any event, within 72 haurs after deat PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY a. STATE b. COUNTY Wicomico Maryland MARYLAND Somerset c. CITY OR TOWN (If autside carparate limits, write RURAL and give neorest town) c. LENGTH OF STAY IN 1b b. CITY OR TOWN (If outside corporate limits, write RURAL ond give neorest town)
Salisbury 33 days Upper Fairmount d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Deer's Head State Hospital NO T YES T 3. NAME OF Lost 4. DATE Manth Day Year DECEASED 19 67 Effie January LAYFTELD DEATH (Type or print) 9. AGE (In years S. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 6. COLOR OR RACE 7. MARRIED **NEVER MARRIED** B. DATE OF BIRTH lost birthdoy) Manths Female White WIDOWED DIVORCED APRIL 23,1892 10b, KIND OF BUSINESS OR 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & Stote, or foreign country) COUNTRY? during mash Early HEEP If WURSES INDUSTRY FAIRMOUNT. MD. U2S.A 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME WARREN LAYFIELD MARGARET HURLEY 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dotes of service MRS. JETTA CATLIN PAIRMOUNT INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: burial-transit ONSET AND/DEATH IMMEDIATE CAUSE (a) signed by DUE TO Canditions, if any, which gave rise ta immediate cause (a), DUF TO stoting the underlying cause as the TO FUNERAL DIRECTOR: After this certificate has been PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? YES X NO for 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City ar town) (Caunty) (State) Hour o.m. Not While foctory, street, office bldg., etc.) While ot work ot work 21. I certify that (I) (this haspital) attended the deceased fram December 1, 19 66 Ata January 3, 1967, that (I) (we) last saw the deceased alive and January 3 1967, and that death accurred at 8:35 M, fram causes and an the date stated above. saw the deceased alive and anuary 3 22g-SIGNATURE 22b. DATE SIGNED **ATTENDING** 1/3/67 DIRECTOR PHYS. M.D. 22d ADDRESS 22c. PHYSICIAN'S NAME (Type) Dr. A. C. Mitchell Deer's Head State Hospital Salisbury Md. director, shauld 23b. DATE THEREOF 1/5/1967 230. BURIAL, CREMATION, BURIAL (Topcify) 23d. LOCATION (City or Tawn) 23c. NAME OF CEMETERY OR CREMATORY (County) (State) FAIRMOUNT CEMETERY FAIRMOUNT, MD. 2Sb. REGISTRAR'S SIGNATURE 2Sa. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR ADDRESS VR A15 (4) 20 M 1/66 LEVIN R. WILSON DATE JAN PRINCESS ANNE. MD.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

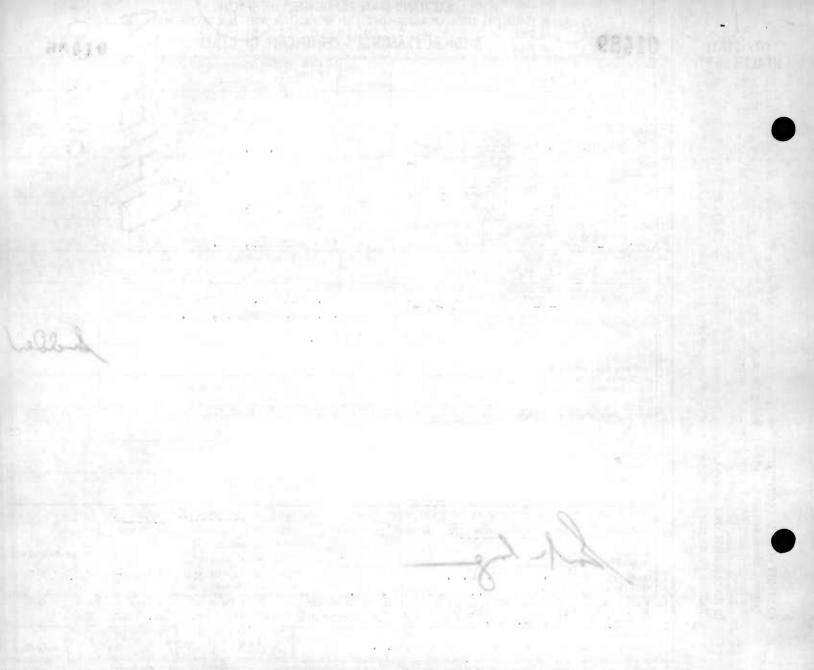
01487 CERTIFICATE OF DEATH 01484 cate be executed within 24 haurs after death. remave carban papers. Pages 1 and 2 n any event, within 72 haurs after death. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Delaware O. COUNTY Wicomico b. COUNTY MARYLAND Sussex b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) and campletely filled in by the remave carban papers. Pages c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 Salisbury Laurel d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) IS RESIDENCE ON A FARM? d. STREET ADDRESS Peninsula General Hospital E.6th St. YES \ NO SC 3. NAME OF First 4. DATE Month Year Lost Doy DECEASED Ca7 19 (0 nos DEATH (Type or print) January 7. MARRIED AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE DATE OF BIRTH NEVER MARRIED last birthdoy) Months Doys Hours and in any WIDOWED DIVORCED 25,1901 Aug. 10o. USUAL OCCUPATION (Give kind of work done 12. CITIZEN OF WHAT 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, ar foreign country) INDUSTRY Railroad COUNTRY? during most of working life, even if retired)
Engineer physician Maryland

14. MOTHER'S MAIDEN NAME IISA 13. FATHER'S NAME burial, crematian, ar remaval, attending phys permit. Then p requires that the death cert Minos LeCates Ida Nachols 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. permit. (Yes, no. or unknown) (If yes give wor or dates of service) No 716-03-1693 Alice LeCates. Laurel 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN signed by the burial-transit p ONSET AND DEATH PART I, DEATH WAS CAUSED BY: ardese arrest IMMEDIATE CAUSE (o) Page 4 may be retained by the haspital ar attending physician. DUE TO Conceneration "entestend obstruct Conditions, if ony, which gove rise to immediate couse (a) DUE TO stating the underlying couse io FUNERAL DIRECTOR: After this certificate has been director, page 3 shauld be detached far use as the af Health priar to ancierma lost. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CERTIFICATION YES NO 20o. ACCIDENT WAS UNDERLYING 205. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER State Dept. 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Day, Year Hour o.m. foctory, street, office bldg., etc.) While Not While of work ot work , 19 that (1) (we) lost 21. I certify that (I) (this hospital) attended the deceased fram 19 , to 3 shauld I with the S 19 , and that death accurred at M. fram causes and on the date stated above. sow the deceosed alive on. 22b. DATE SIGNED 22o. SIGNATURE ATTENDING STAFF directar, page 3 should be filed v M.D. DIRECTOR PHYS. PHYS. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) 23o. BURIAL CREMATION. Burial St Stephens Delmar. -12-67 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Items 7.11.12 Film G385 1/24/67 mh FOR STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01485 HEALTH DEPT. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY o. STATE b. COLINTY delay is and 3 ta of o Maryland Somerset Wicomico death. MARYLAND **Department** b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest tawn) within 72 haurs after Oriole Salisbury IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS Office alang with farm Peninsula General Hospital State [ in Item 18. Give Pages YES NO [ after death. 3. NAME OF Middle Lost 4. DATE Month Doy Year DECEASED OF the OMAR. THOMAS MADDOX 1-12-67 19 (Type or print) DEATH with IF UNDER 24 HRS. S. SFX 6. COLOR OR RACE 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR 7 MARRIED NEVER MARRIED last birthdoy) Months Dovs Hours Male AA WIDOWED DIVORCED 24 haurs event 10g. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? INDUSTRY any Oriole, Md. be executed within 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME .⊆ and 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 INFORMANT Address permit. rd "pending" i Chief Medicaly ar remayal. (Yes, no, or unknown) ((If yes give wor or dotes of service) CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) INTERVAL BETWEEN burial-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Cerebral hemorrhage, with severe facial IMMEDIATE CAUSE (o) This certificate shauld lacerations writing the ward burial, crematian, DUF TO Conditions, if ony, which gove rise to immediate couse (o), DUE TO stating the underlying couse D 0.5 lost. 19. WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) PERFORMED? please execute the certificate. NO X 0 20o. EXTERNAL CAUSE WAS PRIMARY ☑ or CONTRIBUTING □ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) agent, priar 3 should AL EXAMINER: Passenger in auto involved in collision. CAUSE OF DEATH. 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year foctory, street, office bldg., etc.) yaur Not While FUNERAL DIRECTOR: Page of work Somerset. Md. 1-12-6719 Deal Island ot work designated 21. I certify that I took charge of the remains described above, held on Autopsy ... Inspection X Inquiry X ond in my opinion for Homicide | Undetermined monner deoth resulted m: Accident X Noturol couses Suicide CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ar its ASSISTANT MEDICAL EXAMINER SIGNATURE Royer. DEPUTY MEDICAL EXAMINER X January 16, 1967 Earl EXAMINER'S Health ( NAME (Type) Address (Street, city, town, or county) lisbury. Md. 230. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (Stote) 0 REMOVAL (Specify) .lances 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15ME (5) James Funeral Home. Princess Anne. 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Birth certificate in this bureau MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01489 FOR STATE **HEALTH DEPT.** 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY o. STATE b. COUNTY 2, and 3 ta PM3. Page Wicomico with the State Department of within 72 haurs after death. Mary land Wicomico MARYLAND b. CITY DR TDWN (If outside corporate limits, write RURAL and give nearest town)
Sallsbury c. CITY OR TDWN (If outside corporate limits, write RURAL and give neorest town) c. LENGTH DF STAY IN 1b Mardela (Rural) d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE DN A FARM? in Item 18. Give Pages 1, DOA Peninsula General Hospital R. D. #1 YES NO 24 haurs after death. 3. NAME OF First Middle 4. DATE Month Doy Year DECEASED BURNIE MAJORS 1967 January (Type or print) DEATH B. DATE OF BIRTH 1921 IF UNDER 1 YEAR IF UNDER 24 HRS. 5. SEX 6. COLOR OR RACE 9. AGE (In years 7. MARRIED NEVER MARRIED lost, birthdoy) Months Days Hours August 8, 1929 White pages land2 v in any event v Male WIDOWED DIVORCED land 2 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) **INDUSTRY** COUNTRY? Mardela, Md. Laborer - Farmer 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME Examiner Examiner William Frances Majors Beulah Ida Majors Majors and 15. WAS DECEASED EVER IN U.S. ARMED FD RCES? 16. SOCIAL SECURITY NO. INFORMANT This certificate shauld be executed permit. ecute the certiticate, writing the ward "pending".
Page 4 shauld be farwarded to the Chief Medical. used as a burial-transit permit. burial, crematian, ar remaval, (Yes, no, ocunknown) (If yes give wor or dotes of service) Mrs. Ella M. Majors (wife) 216-12-1590 R.D. #1, Mardela, Md. 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: INJERVAL BETWEEN Coronary occlusion. IMMEDIATE CAUSE (o). please execute the certificate, writing the ward DUE TD Conditions, if ony, which gove rise to immediate couse (a) DUE TD stoting the underlying couse PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NDT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS AUTOPSY PERFORMED? NO X pe ar its designated agent, prior ta 20o. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port II of item 1B.) 3 shauld b PRIMARY Or CONTRIBUTING MEDICAL EXAMINER: CAUSE DF DEATH. 20c. TIME OF INJURY Month, Doy, Year Hour o.m. 20d. INJURY DCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) While Not While foctory, street, office bldg., etc.) may be retained far your FUNERAL DIRECTOR: Page While of work at wark Inspection X Inquiry X 21. I certify that taak charge of the remains described obove, held an Autopsy and in my apinion Natural causes X, Accident . Suicide ... Undetermined manner the funeral directar. death resulted fram: Homicide CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE O DEPUTY L. Royer DEPUTY MEDICAL EXAMINER January 16, 1967 EXAMINER'S Earl Health Address (Street, city, town, or county) NAME (Type) . Salisbury, Md. 230. BURIAL, CREMATION, 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) 0 REMOVAL (Specify)
Burial Mardela Memorial Cemetery Mardela, Maryland 2Sb. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR ADDRESS VR A15ME (5) HOLLOWAY & COMPANY, SALISBURY, MD. Charles Judge 1967 6M 1/66

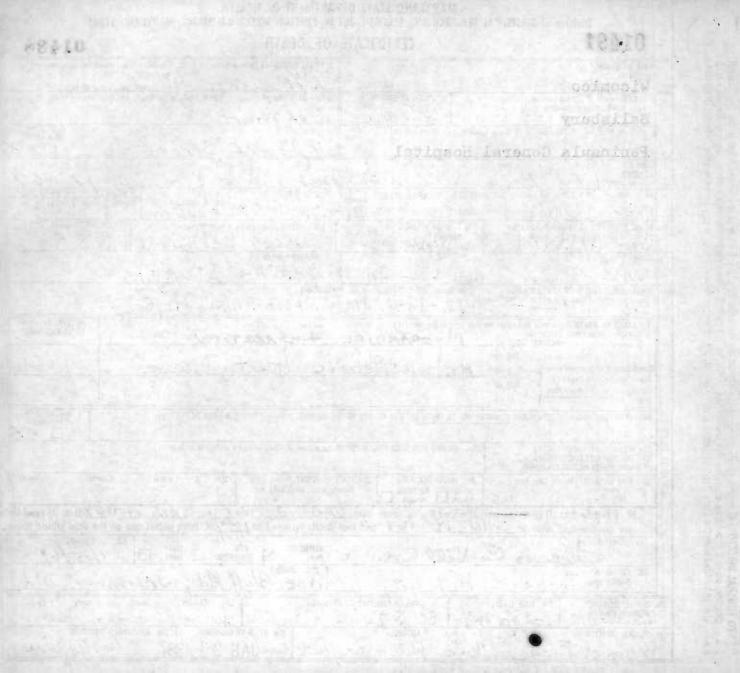


MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 01490 01487 signed by the attending physician and completely filled in by the funeral burial-transit permit. Then please remove carban papers. Pages 1 and 2 burial, cremation, ar remaval, and in any event, within 72 haurs after death. death by the funeral Pages 1 and 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) 1. PLACE OF DEATH . COUNTY Wicomico b COUNTY o. STATE Maryland Wicomico MARYLAND executed within 24 haurs after c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits. c. LENGTH OF STAY IN 16 write RURAL and give nearest town)
Salisbury Salisbury d STREET ADDRESS IS RESIDENCE ON A FARM? completely filled in d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 804 Hanover St. Peninsula General Hospital YES NO IX 3. NAME OF Lost 4. DATE Month Dov Year DECEASED BERRY DEATH 19 (Type or print) AGE In years IF UNDER 1 YEAR IF UNDER 24 HRS. 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH last birthday) Months Hours April 15, 1905 DIVORCED WIDOWED 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT 10b. KIND OF BUSINESS OR 10o USUAL OCCUPATION (Give kind of work done COUNTRY? during most of working life, even if retired) INDUSTRY Malta, Ohio Bakery 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME The law requires that the death certific Harris (Harry) Johnson Martin Mary Elizabeth Berry IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. INFORMANT. (Yes go, or unknown) (If yes give wor or dotes of service) Mrs. Hazel A. Martin (Wife) 804 Hanover St. (Apt. #A) Salisbury, Md. 277:10-9203 INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o' signed by Page 4 may be retained by the haspital ar attending physician. DUE TO Conditions, if ony, which gove rise to immediate couse (o). DUE TO stoting the underlying couse FUNERAL DIRECTOR: After this certificate has been for use as the of Health prior ta 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NO Dease 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH N/A detached (IF EITHER, NOTIFY MEDICAL EXAMINER) directar, page 3 shauld be detache shauld be filed with the State Dept. 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Day, Yeor Not While foctory, street, office bldg., etc.) Hour o.m. 19 ot work ot work 19 60 that (1) (we) last 21. I certify that (1) this haspital) attended the deceased fram \_ > - \$ 19 67 . ta 3 shauld and that death accurred at 7 52 M fram causes and an the date stated above. -6719 saw the deceased alive an 0 22b. DATE SIGNED 22o. SIGNATURE ATTENDING MED. DIRECTOR STAFF PHYS. M.D. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Salisbury, Maryland Dr. John G. Bulkeley 23d. LOCATION (City or Town) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (County) (Stote) 23o. BURIAL, CREMATION, REMOVAL (Specify) Malta(Morgan Co.) Ohio Jan. 13; 1967 Malta Cemetery 0 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR Charley VR A15 (4) 20 M 1/66 HOLLOWAY & COMPANY, SALISBURY, MARYLAND

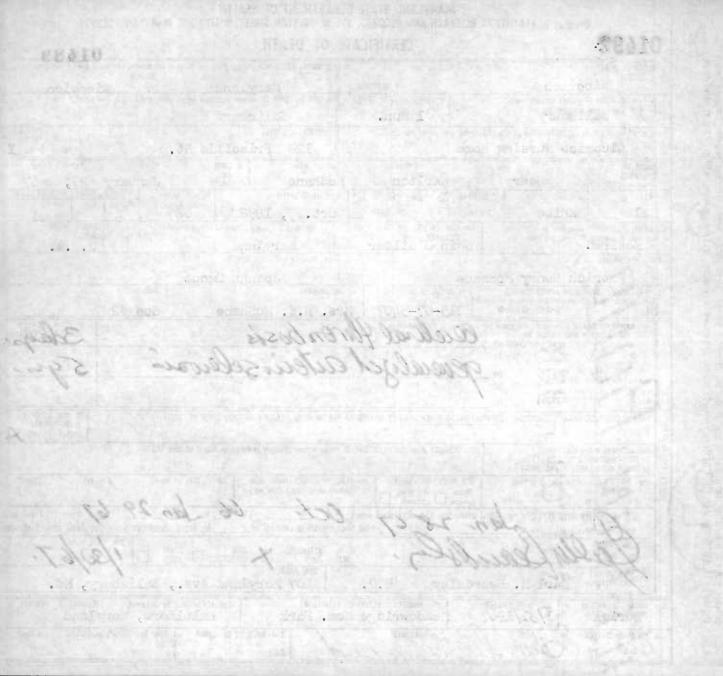
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 01491 CERTIFICATE OF DEATH 01488 CV executed within 24 haurs after death. death. pup 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) and campletely filled in by the funeral remave carban papers. Pages 1 and o. COUNTY Wicomico b. COUNTY remaval, and in any event, within 72 hours after MARYLAND CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1h c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street oddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? NO YES Peninsula General Hospital please remave carban 3. NAME OF First DATE Doy Year DECEASED AM 196 (Type or print) DEATH In years IF UNDER 24 HRS S. SEX DATE OF BIRTH 6. COLOR OR RACE 7. MARRIED NEVER MARRIED birthdoy) Months Doys Hours WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during mast af working life, even if retired) NDUSTRY COUNTRY-? physician DUSSE certificate FUNERAL Dire 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME attending phys 17. INFORMANT WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. requires that the death (Yes, ng, grunknawn) (If yes give war ar dates of service) OF. crematian, INTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) ONSET AND DEATH burial-transit PART I. DEATH WAS CAUSED BY VOCARDIAL IMMEDIATE CAUSE (a) signed by physician. DUE TO burial, Conditions, if ony, which gave rise ta immediate couse (a), DUE TO far use as the t f Health priar to b stating the underlying cause Page 4 may be retained by the haspital ar attending has been last. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CERTIFICATION af Health NO X this certificate 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) State Dept. (State) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) 20c. TIME OF INJURY Manth, Day, Year Haur a.m. Not While foctory, street, office bldg., etc.) While at work ot wark O FUNERAL DIRECTOR: After 14. 1967, that (1) ( last 21. I certify that (1) (this hospital) attended the deceased fram JAN 1967 director, page 3 shauld shauld be filed with the 1967, and that death accurred at 1155M, fram causes and on the date stated above. saw the deceased alive an SAN 22b. DATE SIGNED 22o. SIGNATURE **ATTENDING** MED. DIRECTOR STAFF PHYS. M M.D. PHYS 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 23d. LOCATION (City or Town) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (County) (Stote) 23g. BURIAL CREMATION. KEMOVAL (Specify) emelen 25b. REGISTRAR'S SIGNATURE 2Sa. REC'D BY REGISTRAR ADDRESS 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 01492 CERTIFICATE OF DEATH deoth and completely filled in by the funeral remove carbon papers. Pages 1 and 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH o. COUNTY o. STATE b. COUNTY Wicomico MARYLAND Maryland requires that the death certificate be executed within 24 haurs after Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b Salisbury 1 mon. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Wicomico Nursing Home Priscilla St. 120 YES NO X 3. NAME OF Middle 4. DATE Month Lost Doy Year DECEASED Henry Karlton McShane 19 67 (Type or print) DEATH January S. SEX 6. COLOR OR RACE B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 7. MARRIED **NEVER MARRIED** lost birthdoy) Months Dovs Hours Male White WIDOWED DIVORCED Oct. 3, 1898 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & Stote, or foreign country) during most of working life, even if retired) Ship B uilder COUNTRY? please puo Maryland U.S.A 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME or remaval. Patrick Henry McShane Joanna Smoot attending permit. The 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) ((If yes give wor or dates of service NO Mrs. H.K. McShane See #2 18. CAUSE OF DEATH (Enter only one couse per buriol-tronsit PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) signed by DUE TO Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse the this certificate hos been lost. WAS AUTOPS' PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) PERFORMED? CERTIFICATION NO X YES for 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Day, Year foctory, street, office bldg., etc.) Not While ot work ot work O FUNERAL DIRECTOR: After 2). Letify that (I) (this has ital) attended the deceased from. M, fram causes and an the date stated above. The deceased alive en and that death accurred at 22b. DATE SIGNED DIRECTOR PHYS. M.D. PHYSICIAN'S Earl M. Beardsley NAME (Type) M.D. 207 Maryland Ave., Salisbury, Md. director, 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (Stote) 23o. BURIAL, CREMATION, (County) REMOVAL Spedity) 31/1967 Meadowridge Mem. Park Baltimore, Maryland 256 REGISTRAR'S SIGNATURE 250. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR **ADDRESS** DATE

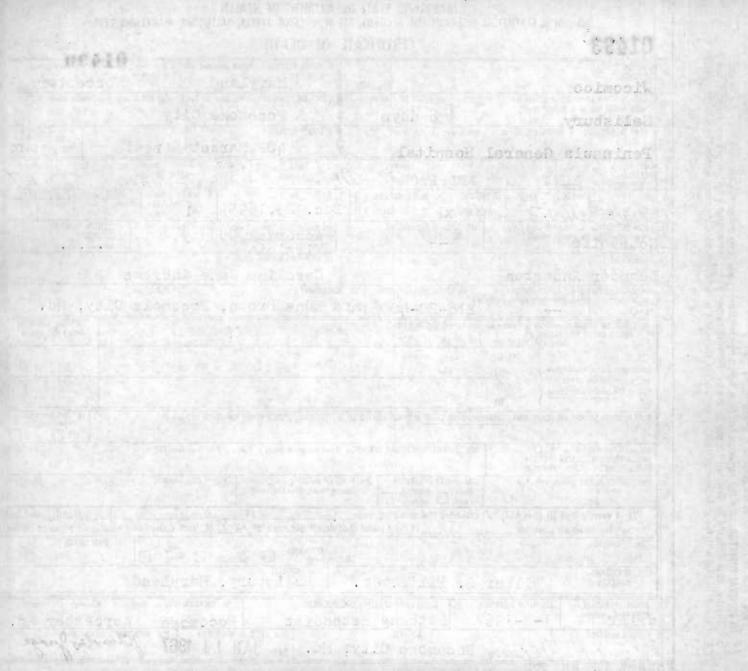


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MARYLAND STATE DEPARTMENT OF HEALTH



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 01491 01494 CERTIFICATE OF DEATH executed within 24 haurs after death. physioton and campletely filled in by the funeral in places. Pages 1 and in any event, within 72 haurs after debth aval, and in any event, within 72 haurs after debth 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH o. COUNTY Wicomico b. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 16 C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS YES TO NO Peninsula General Hospital 3. NAME OF 4 DATE Lost Month Doy Year DECEASED 19 DEATH (Type or print) AGE (In years lost birthdoy) YEAR IF UNDER 24 HRS S SEX 6. COLOR OR RACE DATE OF BIRTH MARRIED NEVER MARRIED Doys Months Hours WIDOWED DIVORCED 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT The law requires that the death certificate be during rabs+ of working life, even if retired) INDUSTRY COUNTRY? EL 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAMI crematian, ar remaval, INFORMANT WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. permit. (Yes, no of unknown) (If yes give wor or dotes of service) 20-0 INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per ling for (o), (b), ond (c). signed by the burial-transit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o' Page 4 may be retained by the haspital ar attending physician. DUE TO burial, Conditions, if ony, which gove rise to immediate couse (a) DUF TO as the stoting the underlying couse O FUNERAL DIRECTOR: After this certificate has been lost. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) CERTIFICATION far use of Health NO 200. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) detached (IF EITHER, NOTIFY MEDICAL EXAMINER with the State Dept. 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month. Day, Year Hour o.m. Not While foctory, street, office bldg., etc.) ot work 19 6/ to 1961, that (1) (-we) last 21. I certify that (1) (this hospital) attended the deceased fram. 1967, and that death accurred at 123M, fram causes and an the date stated above. saw the deceased alive an 22b. DATE SIGNED 220. SIGNATURE STAFF -31-6 M.D. DIRECTOR PHYS. PHYS director, page shauld be filed 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 23d. LOCATION (City or Town) NAME OF CEMETERY OR CREMATORY (Stote) 23o. BURIAL, CREMATION, 23b. DATE THEREOF (County) REMOVAL (Specify) 5 15TEP 2Sb. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR \_FUNERAL DIRECTOR VR A15 (4) 20 M 1/66

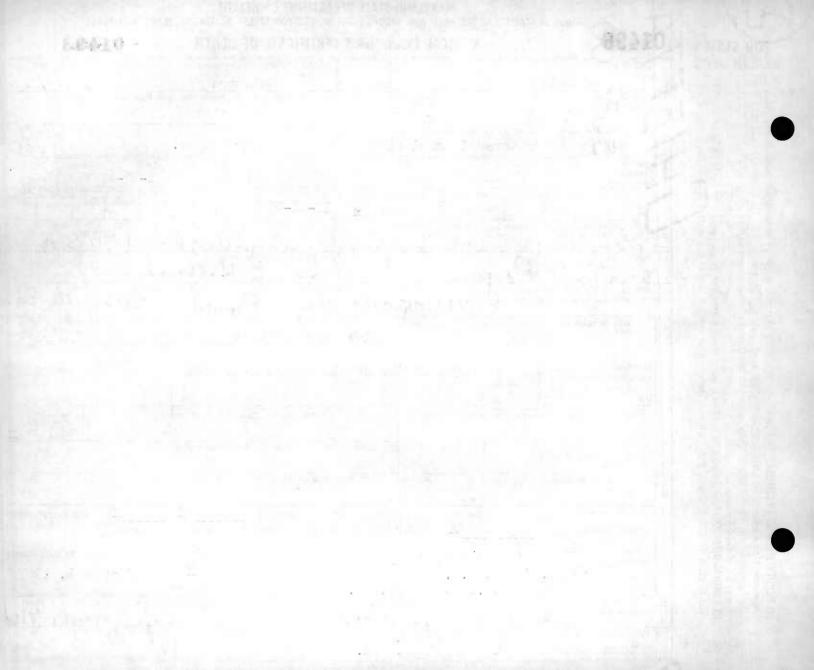
MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W., PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH certificate be executed within 24 hours after death. 2. USUAL RESIDENCE (Where deceosed lived, if institution: Recordence before odmission) PLACE OF DEATH filled in by the funeral popers. Pages I and ...COUNTY Wicomico o. STATE b. COUNTY MARYLAND ve carban popers. Pages I event, within 72 hours after b. CITY OR TOWN (If outside corporate limits, write\_RURAL and give neorest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS Peninsula General Hospital YES NO 3. NAME OF DATE please remove carban First Lost completely DECEASED RENZ DEATH 19 (Type or print) IF UNDER 1 YEAR IF UNDER 24 HRS S. SEX DATE OF BIRTH AGE (In years 6. COLOR OR RACE 7. MARRIED NEVER MARRIED birthdoy) Months Hours and in ony WIDOWED DIVORCED puo 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY\_? AW) AKE JEWELER 13. FAIHER'S NAME 14. MOTHER'S MAIDEN NAME buriol, cremotion, or removol, attending pny 16. SOCIAL SECURITY NO. 17. INFORMANT WAS DECEASED EVER IN U.S. ARMED FORCES? requires that the death permit. (Yes, no, or unknown) (If yes give wor or dotes of service INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).) ONSET AND DEATH buriol-tronsit PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) signed by Page 4 moy be retained by the hospital or attending physician. DUF TO Conditions, if ony, which gove rise to immediate couse (a). DUE TO os the prior to l stoting the underlying couse this certificate has been last. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) detoched for use te Dept. of Health YES T NO 205. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) director, page 3 should be detache should be filed with the State Dept. 20e. PLACE OF INJURY (Home, form, 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED (City or town) (County) (Stote) foctory, street, office bldg., etc.) Hour o.m. Not While 19 ot work ot work O FUNERAL DIRECTOR: After 21. I certify that (I) (this haspital) attended the deceased fram 1962, and that death accurred at 7:30 PM, fram causes and an the date stated above. saw the deceased alive an\_\_\_/-/ 22b. DATE SIGNED 22o. SIGNATURE MED. DIRECTOR PHYS. PHYS. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) dieal. 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (Stote) BURIAL, CREMATION DATE THEREOF (Coupty) EMETE 24. FUNERAL DIRECTOR 25o. REC'D VR A15 (4) 20 M 1/66 DATE

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 01496 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01493 FOR STATE HEALTH DEPT 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY o. STATE b. COUNTY Page 0 Wicomico death. Delaware MARYLAND ond 3 t delay Department b. CITY OR TOWN (If outside carporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town write RURAL and give negrest town) after Selbyville Salisbury d. NAME OF HOSPITAL OR INSTITUTION (II not in hospitol, give street oddress) d. STREET ADDRESS IS RESIDENCE ON A FARM? hours Office along with form DOA Peninsula General Hospital Railroad Ave. State YES T NO T Item 18. Give Pages hours after death. NAME OF Middle 4. DATE lost Month Year within 72 the DECEASED HAZEL BELL MUMFORD 1-27-67 (Type or print) DEATH 19 with 1 IF UNDER 24 HRS 8. DATE OF BIRTH IF UNDER 1 YEAR S. SEX 6. COLOR OR RACE 9. AGE (In years 7. MARRIED NEVER MARRIED lost birthdoy) Months 12-11-05 AA WIDOWED DIVORCED event 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT during mort of working life, even if retired) INDUSTRY ony .⊑ sminer's poges 13. FATHER'S NAME within pencil = ond 16. SOCIAL SECURITY NO. IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT Address be executed (Yes, no, ownknown) (If yes give wor or dates of service permit. or removal, pendin 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY: Acute congestive heart failure IMMEDIATE CAUSE (o) This certificate should ne certificate, writing the word should be forworded to the Ch cremotion, DUE TO Conditions, if ony, which gove Hypertensive cardio vascular disease vears rise to immediate couse (o), DUE TO stoting the underlying couse 0 00 burial, PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS AUTOPSY PERFORMED? CERTIFICATION NO 3 the certificote, pe 0 20o. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) ogent, prior PRIMARY Or CONTRIBUTING CAUSE OF DEATH. 20c. TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour a.m. While Not While factory, street, office bldg., etc.) moy be retoined for your FUNERAL DIRECTOR: Poge 5 may be retained for you TO FUNERAL DIRECTOR: Page Health or its designated a pleose execute ot work ot work 21. I certify that I task charge of the remains described above, held an Autopsy ... Inspection X Inquiry X, and in my opinion Hamicide death resulted frame. Natural causes Accident funerol director. Suicide | Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE L. Royer, DEPUTY MEDICAL EXAMINER February 3, 1967 M.D. Earl EXAMINER'S Sal Address (Street, city, town, or county) NAME (Type) AME-OF CEMEXERY OR CREMATORY 23o. BURIAL CREMATION. 23b DATE THEREOF (Stote) REMOVAL (Specify) 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR FEB VR A15ME (5) Watson Funeral Home, Selbyville. 6M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W, PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 01497 dertificate be executed within 24 haurs after death burial, cremation, ar remaval, and in any event, within 72 haurs after death and campletely filled in by the funeral remave carban papers. Pages 1 and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) ...COUNTY Wicomico a. STATE b. COUNTY MARYLAND b. CITY OR TOWN (If autside corparote limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If-gutside corporate limits, write RURAL and give negrest tawn) write RURAL and give nearest town)
Salisbury d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? main Peninsula General Hospital NO X YES | 3. NAME OF 4. DATE Year DECEASED (Type ar print) DEATH . S. SEX IF UNDER YEAR IF UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH birthday) Manths Days Hours X WIDOWED DIVORCED 10b. KIND OF BUSINESS OR 10o. USUAL OCCUPATION (Give kind af work done 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) during roose of warking life, even if retired) INDUSTRY torner nun 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME attending p IS. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, ar upknown) (If yes give wor or dates of service) 17. INFORMANT 16. SOCIAL SECURITY NO permit. INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c). signed by the burial-transit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if ony, which gave rise ta immediate cause (a). **DUE TO** stoting the underlying couse d far use as the af Health priar to WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CERTIFICATION NO TO FUNERAL DIRECTOR: After this certificate Page 4 may be retained by the haspital ar 20a. ACCIDENT WAS UNDERLYING □ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I ar Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) director, page 3 shauld be detache shauld be filed with the State Dept. 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (City or town) (County) (State) Haur a.m. While Nat While factory, street, affice bldg., etc.) at work at work (1) (we) last 21. I certify that (I) (this hospital) ottended the deceased from 190 L. to M, from couses and an the date stated above. sow the deceased olive on and that death occurred at 22n. SIGNATURE 22b. DATE SIGNED STAFF M.D. DIRECTOR PHYS. PHYS. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23a. BURIAL CREMATION 23b. DATE THEREOF (County) (Stote) EMOVAL (Specify) 2Sa. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR VR A15 (4)

NOTE THE TIER PERMITTED SERVICES AND THE PERMITTED TO THE PERMITTED TO THE PERMITTED TO THE PERMITTED TO THE P 584J.0 obligooli Ferinaula General Mespital

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 01498 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STAT 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before damission) HEALTH DEP PLACE OF DEATH a. COUNTY o. STATE b. COUNTY delay is ond 3 to of Wicomico Maryland Wicomico MARYLAND b. CITY OR TOWN (If autside carparote limits, c. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b write RURAL and give neorest town)
Salisbury within 72 hours ofter Salisbury d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Office olong with form Item 18. Give Pages 1, 332 Lake St. 332 Lake St. YES NO DE 24 hours after deoth. 3. NAME OF First Middle Last 4. DATE Year DECEASED EVELYN MANUEL NICHOLS 1-24-67 19 (Type or print) DEATH 9. AGE (In years last birthdoy) IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH Hours 9-21-1915 AA WIDOWED 🔀 DIVORCED event 10b, KIND OF BUSINESS OR 11. BIRTHPLACE (Stote or foreign country) 10o. USUAL OCCUPATION (Give kind of work dane 12. CITIZEN OF WHAT COUNTRY? during most of warking life, even if retired) INDUSTRY Domestic Ocean City, Md. \_\_ 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME pencil be executed within William F. Manuel Louise Pitts 332 Addresse St. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FOR LESS (Yes, no, ar unknown) (If yes give war ar dates at service) 213-16-4750 or removal, Venitta H. Dashiell Salisbury, Md. 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) INTERVAL BETWEEN PART I. DEATH WAS CAUSED 8Y: Coronary occlusion IMMEDIATE CAUSE (a) This certificate should writing the word cremation, DUF TO Canditions, if any, which gave rise to immediate couse (o), DUE TO stating the underlying cause 19. WAS AUTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO X the certificate, YES designoted ogent, prior to 20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) PRIMARY ar CONTRIBUTING CAUSE OF DEATH 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City ar tawn) (Caunty) (Stote) 20c. TIME OF INJURY Month, Day, Year foctory, street, office bldg., etc.) FUNERAL DIRECTOR: Page at wark at wark 21. I certify that I took charge of the remains described above, held an Autapsy Inspection X. Inquiry 3 and in my apinian death resulted frame Natural cause X Accident . Suicide . Homicide | Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE EXAMINER'S Earl L. Royer, M. Dalisbury, Md. January 27, 1967 DEPUTY MEDICAL EXAMINER X 5 may 10 FUNE Address (Street, city, tawn, ar caunty) 23a. BURIAL, (REMATION, REMOVAL (Specify) Durial 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (State) Salisbury, Wicomico, Md. 1-27-67 Green Acres Pk. 2Sb. REGISTRAR'S SIGNATURE 2Sa. REC'D BY REGISTRAR ADDRESS 24. FUNERAL DIRECTOR Ocharles VR A15ME (5) DATE JAN Jolley Funeral Home, Rt. 2, Salisbury, Md. 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 01499 death funeral 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 1. PLACE OF DEATH Wicomico o. STATE b. COUNTY Wicomico Maryland MARYLAND Man and campletely filled in by the fur lease remove carban papers. Poges 1 and in any event, within 72 haurs after c. CITY OR TOWN (If autside corparate limits, write RURAL and give nearest town) b. CITY OR TOWN (If autside carparate limits, c. LENGTH OF STAY IN 1b write RURAL and give nearest tawn) Salisbury Salisbury IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS filled Rt. #5. Old Quantico Rd. NO NO Peninsula General Hospital YES 3. NAME OF DATE Last Manth Day Year DECEASED FLORENCE 196 DEATH (Type or print) IF UNDER 24 HRS DATE OF BIRTH AGE (In years 1 YEAR S SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED last birthday) Months Doys Hours July 7, 1881 White Female X DIVORCED WIDOWED 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT 10g. USUAL OCCUPATION (Give kind of work done COUNTRY? during mast of working life, even if retired) **INDUSTRY** physician o Pittsville, Maryland 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME burial, crematian, ar removal, Dora E. Truitt Annie Farlow 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMAN Mr. Otis R. Parker (Son) (Yes, no, ar unknown) (If yes give war or dates af service #5. Old Quantico Rd. Salisbury. no INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) signed by the burial-transit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY: menulas IMMEDIATE CAUSE (o) Page 4 may be retained by the haspital ar attending physician. DUE TO Conditions, if any, which gave rise to immediate cause (a), DUE TO stating the underlying cause TO FUNERAL DIRECTOR: After this certificate has been Health priar ta far use as the cen PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? NO YES 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH State Dept. af detached N/a (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) (County) (State) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, Haur o.m. Not While factory, street, affice bldg., etc.) 19 at wark at work 1965, that (I) (we) last 21. I certify that (I) (this haspital) attended the deceased fram. 19 4 3 10 3 shauld director, page 3 shauld shauld be filed with the 1967, and that death accurred at 43 M, fram causes and an the date stated above. saw the deceased alive an 22a. SIGNATURE 22b. DATE SIGNED **ATTENDING** /1967 Jan. M.D. PHYS. DIRECTOR PHYS. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Dr. William D. Grav 334 Camden Avenue, Salisbury, Maryland 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) 23b. DATE THEREOF 23a. BURIAL CREMATION. REMOVAL (Specify) Salisbury, Maryland Parsons Cemetery 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND

1967

DATE

requires that the death certificate be executed within 24 haurs after death

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1. MARYLAND CERTIFICATE OF DEATH after 2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before edmission) 1. PLACE OF DEATH e. COUNTY b. COUNTY 12g and 2 death. MARYLAND Marvland Wicomico Wicomico b. CITY OR TOWN (if outside corporete limits. c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporete limits, write RURAL end give neerest town) 24 write RURAL and give nearest town) .5 7 Salisbury Pages Salisburv filled i d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) papers. Pagin 72 hours . IS RESIDENCE d. STREET ADDRESS ON A FARM? completely YES NO Stowart Stawart 3. NAME OF 4. DATE Middle Month Day Yeer DECEASED OF (Type or print) DEATH 1967 Wright withir Fannie Parson January 6. COLOR OR RACE 7. MARRIED NEVER MARRIED S. SEX 8. DATE OF BIRTH 9. AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. and lest birthdey) Months Davs Hours WIDOWED A remove 10e. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) U.S.A. House arvland C 14. MOTHER'S MAIDEN NAME ding 13. FATHER'S NAME 귭 Sidney Wright 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address Salis-Md. (Yes, no, or unkown) | (If yes give we ror detes of service) Booth Catherine, Salhy St. þ 18. CAUSE OF DEATH [Enter only one cause per/ine for (a), (b), and (c). OMSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) DUE TO gave rise to immediate cause DUE TO (e), steting the underlying PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY CERTIFICATION PERFORMED? USe prior NO [ YES T Po 200. ACCIDENT WAS UNDERLYING 20b, DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING | CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, ferm, 20f. (City or town) (County) (State) ō fectory, street, office bldg., etc.) While Not While Hour e.m. Dept. at work et work p.m. DIRECTOR
3 should be ...., that (1) (we) las saw the deseased alive on DATE 22a. SIGNATUR ATTENDING MFD. STAFF SIGNED death. Page 4 PHYS. DIRECTOR PHYS. M.D. ADDRESS 22c. PHYSICIAN'S 22 de NAME (Type ector, filled 23d. LOCATION (City, town or county) 230, BURIAL, CREMATION, 23b. DATE THEREOF 13c. NAME OF CEMETERY OR CREMATORY (State) क्षेत्रं व REMOVAL (Specify) Salisbury Green 24 FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A15 (4)

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral and PLACE OF DEATH a. COUNTY USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) h. COUNTY after within 72 hours after Wicomico Maryland Wicomico MARYLANO by the Pages CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) hours Salisbury Parsonsburg (Rural = filled d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e. IS RESIDENCE ON A FARM? d. STREET ADDRESS 112 E. London Avenue NO YES completely carbon 3. NAME OF First Middle Last 4. DATE Month Day Year DECEASED in any event, (Type or print) FRED 19 67 HENRY PARSONS DEATH January 6. COLOR OR RACE | 7. MARRIED 5. SEX DATE OF BIRTH AGE (In years | IFUNDER 1 YEAR | IFUNDER 24 HRS remove NEVER MARRIED last birthday) | Months | Davs Hours and May 9. Male White WIDOWED. DIVORCED 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT physician 11. BIRTHPLACE (County & State, or foreign country) ease COUNTRY? and Junk Dealer Parsonsburg, Md. USA certificate 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME remova attending parmit. Ther George B. Cyrus Parsons Vianna Wells 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. transit permit. (Yes, no, or unkown) (If yes give war or dates of service) death Mrs. Ann W. LeCates (niece No . Delaware the 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c), ] INTERVAL BETWEEN FUNERAL DIRECTOR: After this certificate has been signed by t irector, page 3 should be detached for use as the burial-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: be retained by the hospital or attending physician. IMMEDIATE CAUSE (a burlal, DUE TO Conditions, if any, which (b) gave rise to immediate the r DUE TO cause (a), stating prior underlying cause last. (c) CERTIFICATION WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) for use YES NO ! 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20a. ACCIDENT WAS UNDERLYING detached for the Dept. of h OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A MEDICAL 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, (State) 20c. TIME OF INJURY Month, Day, Year 20f. (City or town) (County) factory, street, office bldg., etc.) Hour a.m. While Not While ATTENDING at work at work 21. I certify that (I) (this hospital) attended the deceased from 19 to. 19 that (I) (we) last and that death occurred at STAM, from the causes and on the date stated above. saw the deceased alive on. 22b. DATE SIGNED 22a. SIGNATURE ge ATTENDING PHYS. MED. DIRECTOR Page 4 may b M.O. PHYS. director, pag should be file 22d. ADDRESS PHYSICIAN'S 22c. NAME (Type) Salisbury, Maryland Carrie Hearn 23d. LOCATION (City, town or county) (State) BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23a. 2 Parsonsburg, Maryland
REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE Burial Parsonsburg Cemetery Jan. 28.1967 24. FUNERAL DIRECTOR ADDRESS Charles HOLLOWAY & COMPANY, SALISBURY, MARYLAND VR A15 (4) 15M 4-64

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01502 CERTIFICATE OF DEATH 01499 be executed within 24 haurs after death. and 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) completely filled in by the funeral nave carban papers. Pages 1 and PLACE OF DEATH o. COUNTY Wicomico o STATE Maryland burial-transit permit. Then please remave carban papers. Pages 1 burial, crematian, ar removal, and in any event, within 72 hours after MARYLAND Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Salisbury c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) Salisbury 3 Wks. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS Oak Hill Town House Peninsula General Hospital YES NO X 3 NAME OF 4 DATE First Year DECEASED WILLIAM RAYMOND DEATH (Type or print) S. SEX B. DATE OF BIRTH AGE (In years IF UNDER 1 YEAR 6. COLOR, OR RACE 7. MARRIED DX. NEVER MARRIED last birthday) Months Days Haurs Dec. 26, 1892 WIDOWED DIVORCED 12. CITIZEN OF WHAT 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or fareign country) COUNTRY? during mast of warking life, even if retired)
Ret. Distr. **INDUSTRY** Iowa Beer requires that the death certifical 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Clementine Hanna Raymond S. Pease 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, na, ar unknawn) (If yes give war ar dates af service) 17. INFORMANT 16. SOCIAL SECURITY NO Address Mrs. Louise H. Pease. Sec. 2 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN signed by the burial-transit p ONSET AND DEATH IMMEDIATE CAUSE (a) Page 4 may be retained by the haspital ar attending physician. DUF TO wics Canditians, if any, which gave rise ta immediate cause (a), DUE TO stating the underlying cause **IO FUNERAL DIRECTOR:** After this certificate has been director, page 3 should be detached for use as the should be filed with the State Dept. of Health priar to last. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) YES DO NO 20g. ACCIDENT WAS UNDERLYING 205. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City ar tawn) (Caunty) (State) 20c. TIME OF INJURY Manth, Day, Year Haur a.m. Not While factory, street, affice bldg., etc.) at work 1967, that (1) (we) last 21. I certify that (1) (this haspital) attended the deceased fram. 123 19 67, and that death accurred at 53 AM, from causes and an the date stated above. saw the deceased alive an 22b. DATE SIGNED 22a. SIGNATURE ATTENDING PHYS. 1-25-1967 X M.D. DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Tawn) (Caunty) (State) 23a. BURIAL, CREMATION REMOVAL (Specify) Parsons Cemetery Salisbury, Maryland 1-26-1967 REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR liayer VR A15 (4) 20 M 1/66 Salisbury, MAryland Hill Funeral Home



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

		0150	3		CERTI	FICATE	OF DEATH		0	1500
f		LACE OF DEATH					2. USUAL RESIDENCE (W	here deceased lived, i		e before admission)
1	(	Wicomi	co		MΔ	RYLAND	o. STATE Maryla	and	b. COUNTY	omico
ŀ	ŀ		f outside corporate limits.				c. CITY OR TOWN (If our			
		Salisb	give negrest town)		Adm. in	1 D	Salish			22.1
Ì	(	. NAME OF HOSPITA	AL OR INSTITUTION (If not	t in haspitol, g	ive street oddress)		d. STREET ADDRESS	71-12 Lynn		e. IS RESIDENC ON A FARM
		Penins	ula Gener	al Ho	spital		R.D. #	5. Parker	Road	YES NO
Î		NAME OF	Firs	st	Middle		Lost	4. DATE	Month	Day Year
ı		Type or print)	Georg	16	Edwar	d	Petts. Jr	OF DEATH \	TANUARY	27 19 6
Ì	S. 5		6. COLOR OR RACE		NEVER MARRI		DATE OF BIRTH	9. AGE (In	yeors IF UNDER 1	
		male	White	WIDOWED	DIVORC	ED 🗍	Oct. 27, 190		yrs. 3	O Hours M
l		USUAL OCCUPATION ng most of working	(Give kind of work done		ND OF BUSINESS OR DUSTRY		11. BIRTHPLACE (County )	& State, ar fareign count		ZEN OF WHAT INTRY?
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İ	13.	FATHER'S NAME		M. C. Y			14. MOTHER'S MAIDEN N	AME		
I		George E	dward Petts	. Sr.			Margaret A	nna Walkl	ing	
ľ	15.	WAS DECEASED EVE	R IN U.S. ARMED FORCES?	16. 9	SOCIAL SECURITY NO.	17, 1	VEORMANT		Address	BL HOLL
ł	(16:	No.	(If yes give war ar dotes of	Service) 21:	2-07-8110	R	s. Mildred D. #5. Park	er Road.	wire)	Md.
ŀ	1	18. CAUSE OF DE	ATH (Enter only one cous H WAS CAUSED BY:	se per line for	(o), (b), ond (c).)	-	1 1			INTERVAL BETWEEN
I	П	27	IMMEDIATE CAUSE (	0) ce	reprol	- 1	nrombosi.	2		
I		5 50	DUE 1	TO (3	-11	1	Linna - 1	work a	1	
ı		Conditions, if ony, rise to immediate		(b) C	he blou	17	terroscle	10515	· <u>c</u>	
١	Ŋ	stoting the under	lying couse DUE	10 He	per te	usic	n			
I	1						HE TERMINAL DISEASE CON	DITION CIVEN IN DART	1(0)	19. WAS AUTOPSY
	MEDICAL CERTIFICATION	PAKI II. UIHEK SI	MIFICANT CONDITIONS CC	NIKIBUIING	U WEATH BUT NOT K	ELAIED IO I	HE TERMINAL DISEASE CON	UIIION GIVEN IN PAKI	1(0)	PERFORMED? YES NO
I	띎	200. ACCIDENT WAS		205. DES	SCRIBE HOW INJURY	OCCURRED.	Enter noture of injury in F	Port I or Port II of item	18.)	
l	8		CAUSE OF DEATH MEDICAL EXAMINER)		N	/A				
١	N N	20c. TIME OF INJU	IRY Month, Doy, Year		JURY OCCURRED	20e. PLAC	E OF INJURY (Home, form	, 20f. (City or	own) (Cou	nty) (Stote
Į	WE	Hour a.n	10	While of work		tocto	ory, street, office bldg., etc.)	A CUIT ELLS		
l						d fram	IAN 17,1	967 to 57	W 27 . 196	7. that (1) (3ve)
ł		saw the de	eceased alive an	Jan 2	6 1967	and that	death occurred at	450 M, fram (	auses and an th	e date stated ab
ı		220. SIGNATURE						1	22b. DA	TE SIGNED /
l			homas	0	11:00 0	M.C	ATTENDING PHYS.	MED. STA		127/67
l		22c. PHYSICIAN'S	VCETTUCAL		Nacy .	A .	22d. ADDRESS	/	J	1
l		NAME (Type)	Dr. Thoma	as C. I	Hill, Jr.	/	Pine B	luFF Rd,	SALISBO	IRY Md
ŀ	230	BURIAL, CREMATIC	IN, 23b. DATE THE	REOF	23c. NAME OF CE	METERY OR	REMATORY	23d. LOCATION (C	ty or Town)	(County) (State)
1		REMOVAL (Specify Burial					n Cemetery		ister, Ma	ryland
1	24	FUNERAL DIRECTO		TIADL	ADDRESS	-L dire	2So. REC'D	BY REGISTRAR	2Sb. REGISTRAR'S SI	GNATURE
1			Y & COMPANY	. SALI	SBURY, MA	RYLAN	D 2478 11	0 0 4007	Ochande	2. Judge.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physicion and completely filled in by the funeral director, page 3 shauld be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremotion, or removal, and in any event, within 72 haurs after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or ottending physicion.

VR A15 (4) 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 01504 by the funeral Poges 1 and 2 2. USUAL RESIDENCE (Where deceased lived, if institution: Residen 1. PLACE OF DEATH d. COUNTY Wicomico o. STATE b. COUNTY MARYLAND b. CITY OR TOWN (If autside carparate limits, write\_RURAL and give nearest tawn) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside corparate limits, write RURAL and give nearest tawn) Salisbury filled in d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Peninsula General Hospital YES NO 3. NAME OF Lost DECEASED DEATH (Type or print) AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED last birthdoy) Manths Days Hours

> 12. CITIZEN OF WHAT COUNTRY?

> > INTERVAL BETWEEN

ONSET AND DEATH

19. WAS AUTOPSY PERFORMED?

NO

(State)

(State)

YES

(Caunty)

**DATE SIGNED** 

(County)

REGISTRAR'S SIGNATURE

2So. REC'D BY REGISTRAR

2Sb.

be executed within 24 haurs after death Flose remove corbon papers. Poges 1 and 2 ond in ony event, within 72 hours after death completely WIDOWED DIVORCED ond 10a, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR during most of working life, even if retired) **INDUSTRY** physkian The law requires that the deoth certificate borg MOTHER'S MAIDEN NAME 13. FATHER'S NAME ottending pnyburial, cremotian, or removal, 17. INFORMANT WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address permit. (Yes, no, or unknown) (If yes give war, or dates of service mown CAUSE OF DEATH (Enter anly one cause per line for (a), (b), and (c) signed by the burial-tronsit PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Page 4 may be retained by the haspitol or attending physician. DUE TO Conditions, if any, which gave (b) rise ta immediate cause (a) DUE TO as the prior to l stoting the underlying couse this certificate has been last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CERTIFICATION be detoched far use State Dept. of Heolth 205, DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) 20a. ACCIDENT WAS UNDERLYING [ OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Hame, farm, 20c. TIME OF INJURY Month, Day, Year (City or town) foctory, street, office bldg., etc.) Hour o.m. While Not While OR ATTENDING 19 at wark at wark After 21. I certify that (1) (this haspital) attended the deceased fram. M, from causes and an the date stated abave. 3 shauld k and that death accurred at 610 19 TO FUNERAL DIRECTOR: saw the deceased alive art 22n, SIGNATURE STAFF **ATTENDING** noor director, page 3 should be filed v DIRECTOR PHYS. M.D. PHYS. ADDRESS 22c. PHYSICIAN'S NAME (Type) uni sula 001 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Jawn) 23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify)

**ADDRESS** 

VR A15 (4) 20 M 1/66

24. EUNERAL DIRECTOR

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

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aurs after death. by the funeral Pages 1 and 2 naurs after death.		PLACE OF DEATH	MX LOUIS				SIDENCE (W	here deceas	ed lived, if institut		e befare admis	ion)
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fer fter	_	Wicom			MARYLAND LENGTH OF STAY IN 1b	- CITY OD TO			te limits, write RU			
the the ages after a a		<ul> <li>CITY OR TOWN (If autsident write RURAL and give n</li> </ul>	e carparate limits,	(	LENGIN OF SIAT IN ID	C. CITT OK IC	JANN (IT OUTS	side carpora	re limits, write KU	KAL ond give	nearest rown)	,
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within 24 haurs after lely filled in by the fur bon papers. Pages 1 within 72 haurs after		NAME OF DECEASED	First		Middle	Last		4. DATE OF	Mon			ear
a de de	30	Type ar print)	John		H. (Till)	REED,	Jr.	DEATH	Januar	,		67
campletely ave carbor y event, wi	S.	6. CO	LOR OR RACE 7. M.	ARRIED	NEVER MARRIED X	8. DATE OF BIR	TH	9.	AGE (In years		YEAR IF UND	
car car		Male W	hite Wil	DOWED	DIVORCED	May 20.	1876		last birthdoy) 90 yrs.	Months	Doys Hours	Min.
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be carried and din din	duri	ng mast of working life, eve Retired - Fa	n if retired)	INDU	TRY ming	Table 1 and 1 and 1 and 1				COL	NTRY?	
rite ciar eas and			rmer	Far	ming				, Maryla	nd US	A.	
di ysi	13.	FATHER'S NAME				14. MOTHER'S	S MAIDEN NA	AME				
equires that the death certificate be executed verysician. Signed by the attending physician and camplet burial-transit permit. Then please remave carburial, crematian, ar remaval, and in any eventy		John H. Reed	. Sr.			Henn	ie					
ne death ce attending p permit. The ian, ar remo	15	WAS DECEASED EVER IN ITS	ARMED FORCES?	16. SOC	IAL SECURITY NO. 17	INFORMANT			Addr	ess		
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erm erm in,		No				Pine Kn	OILT	errac	e,R.D. 3	, Sali		
the the		18. CAUSE OF DEATH (E PART I. DEATH WAS	nter only one cause per	line for (o)	, (b), ond (c).)	. 7 . 4.3				1,50	INTERVAL B	DEATH
in the state of th		PAKI I. DEATH WAS	MMEDIATE CAUSE (a)	Recu	rrent cerebi	at throi	ndosis	3		44	SWEET AND	KS
quires th physician. signed by burial-trai		332X	DUE TO				7			F-1	Voor	
ries /sic /sic ial- ial-		Conditions, if any, which	gave ) (b)	Arte	riosclerosi	, genera	al .				Years	
phy		nse to immediate cous	e (a), ( DUE 70					3/4	The state of the s			
ng en en ta		stoting the underlying of	ouse							145		
be be iar iar		last.	) (c)								19. WAS AU	TODCY
G PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death the haspital ar attending physician.  This certificate has been signed by the attending physician and campletely filled in by the funeral detached far use as the burial-transit permit. Then please remave carbon papers. Pages 1 and 2 detached far use as the burial, crematian, ar remaval, and in any event, within 72 haurs after death the Dept. of Health priar to burial, crematian, ar remaval, and in any event, within 72 haurs after death.	× I	PART II. OTHER SIGNIFICA	NT CONDITIONS CONTRIB	BUTING TO	DEATH BUT NOT RELATED T	O THE TERMINAL D	ISEASE CONL	DITION GIVE	N IN PART I(a)		PERFOR	MED?
r after at	CERTIFICATION									5347.11	YES 🗶	NO
lAN: al ar ficate far us Healt	E	20o. ACCIDENT WAS UNDER		20b. DESCR	IBE HOW INJURY OCCURRE	D. (Enter nature a	f injury in P	art I ar Part	t II af item 18.)	7 1 1 1 1	The Property	11233
ロぎ着きゃ	ERI	OR CONTRIBUTING CAU			N/A							
PHYSICIA ne haspital this certifica etached fa Dept. af H	MEDICAL	20c. TIME OF INJURY Mo		204 INTII		PLACE OF INJURY (	Home form	20f.	(City or town)	· (Cou	ntv)	(State)
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by the little the be de State	Σ	p m.	19	at work L	ot wark				4			
S e d t e		21. I certify the	t (I) (this haspital)	attende	d the deceased fram	March 7	, 19	9 66, 1	January	25 19 0	21, that (I)	(we) last
the draw the		sow the deceose	d alive on Janu	ary 2	5_1967_, and t	hot death acc	urred of	3:15PN	I, from couses	ond on th	ne dote stat	ed above.
<b>F</b> 章 <b>C</b> 宏 年		22a. SIGNATURE	( , /	1			278	-			TE SIGNED	
% 3 <b>RE</b> 6 ×		1400	notch	111		M.D. PHYS.	' 🗆 i	MED. DIRECTOR	PHYS.		L-26-67	
o a a a a		22c. PHYSICIAN'S	100			22d. ADI	ORESS					
AL PE PE PE			. A. C. Mi	tchel	1	Deer	s Hea	d Sta	te Hospi	tal, Sa	alisbur	y,Md.
TO HOSPITAL OR ATTENDING Page 4 may be retained by th TO FUNERAL DIRECTOR: After i director, page 3 shauld be d shauld be filed with the State												
Ban	230	BURIAL, CREMATION,	23b. DATE THEREOF		23c. NAME OF CEMETERY				CATION (City or To		. ,,	(Stote)
020gg V		REMOVAL (Specify) Burial	Jan. 28.1	967	Bethel Chur	ch Cemet	ery		ton, Sal			Tand
The same of the	24	. FUNERAL DIRECTOR			ADDRESS		2Sa. REC'D		AR 2Sb. R	EGISTRAR'S SI	GNATURE Ja	.100
VR A15 (4)		HOTTOWAY &	COMPANY.	SALIS	BURY. MARYL.	AND	DATE	JAN 2	7 1967	your	was the	0

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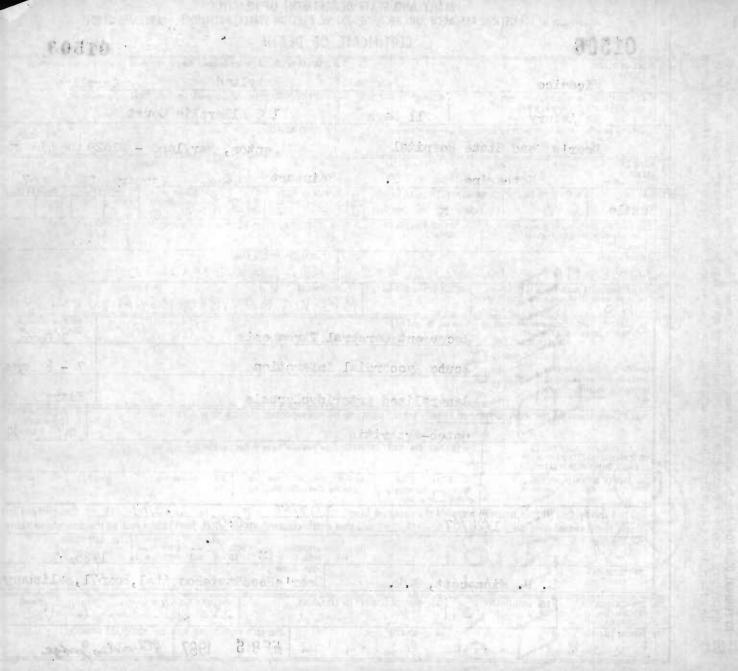
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the haspital ar attending physician.

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

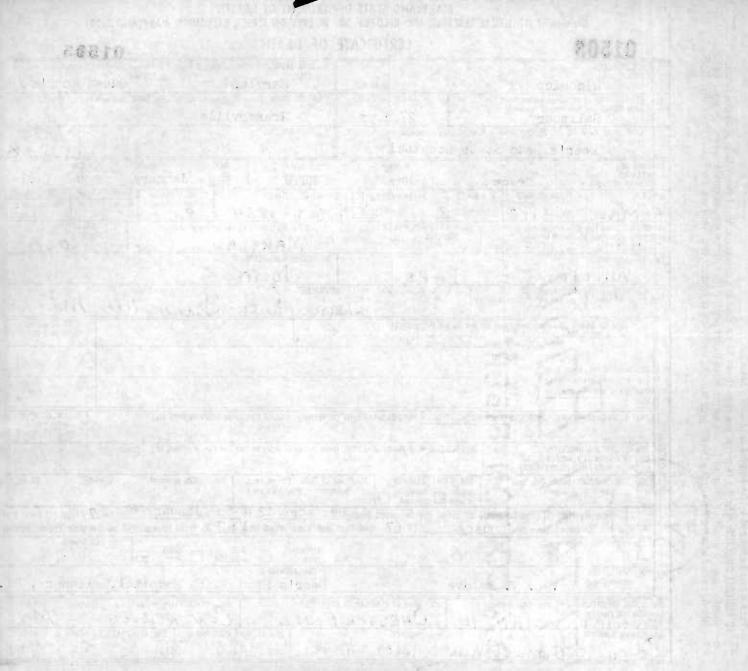
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l		De	er's Head	State :	Hospital		Det	nton, Mar	yland -	21629	YES NO 🔀
Ī		NAME OF		rst	Middle		Lost	4. DATE OF	Month	1	Doy Year
	(	DECEASED Type ar print)	Kath	erine	S.		Reinhart	DEATH	Janu		19 67
4	S. 5		6. COLOR OR RACE	7. MARRIED	NEVER MARR		B. DATE OF BIRTH		GE (In years st birthdoy)	Manths De	EAR IF UNDER 24 HRS. ays Hours Min.
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ŀ		1B. CAUSE OF DI	ATH (Enter anly one cau						Transfer Van		INTERVAL BETWEEN
ı		PAKI I. DEAI	TH WAS CAUSED BY:  IMMEDIATE CAUSE	(o) Re	current C	erebra	al Thrombo	sis			ONSEL AND DEATH
ı		33d	X naue	ТО			m 0- 14-				- 0 -
ı	3	Canditians, if any	e couse (a)	. ,	ube Myoca	rdial	Infarctic	a			7 - 8 Days
	Н	stating the unde									Years
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l	NO	PART II. OTHER SI	GNIFICANT CONDITIONS		The same of the sa		HE TERMINAL DISEASE	CONDITION GIVEN IF	PART I(a)		PERFORMED?
١	CAT				teo-Erthr		(F. )	2 Death of Death	-(: 10)		YES NO X
	L CERTIFICATION		CAUSE OF DEATH MEDICAL EXAMINER)				(Enter noture of injury				
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		21. I certi	<b>fy</b> that (I) (this has eceased alive an_	pital) otter 1/28/6	ded the decease	d fram , and tha	1./1.7/67 t death accurred	, 19 to at 10:05 M, f	1/28/6 rom causes	and an the	, that (I) (we) los date stated abave
		22g. SIGNATURE	Dinn	GC O		M.M		MED. DIRECTOR	STAFF PHYS.	22b. DATE	SIGNED 28/67
		22c. PHYSICIAN'S NAME (Type		Vinnaco	tt, M.D.		22d. ADDRESS Deer's He				l,Salisbur
	230	BURIAL, CREMATIC REMOVAL (Specify	ON, 23b. DATE TH	EREOF 1,1967	23c. NAME OF CE	METERY OR	ord	Sher	ION (City or Tov	guesas	oynty) (State)
	24	PUNERAL DIRECTO	Resila	core	ADDRESS (	los	hid DATE	B 6 196	The second second	GISTRAR'S SIGN	



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 01507 CERTIFICATE OF DEATH signed by the ottending physician and completely filled in by the funeral burial-transit permit. Then please remove carbon papers. Pages 1 and 2 burial, cremation, or removal, and in any event, within 72 hours after death. within 24 hours after death 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH a. COUNTY Wicomico b. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b TOWN (If autside carparate limits, write RURAL and give nearest tawn) write\_RURAL and give neorest town) Salisbury IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS Peninsula General Hospital YES NO P 3. NAME OF Middle 4. DATE Month Doy Year Lost DECEASED OF Nileu 19 61 DEATH (Type ar print) be executed S. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DATE OF BIRTH AGE (In years lost birthday) Manths Days Haurs WIDOWED DIVORCED 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 1). BIRTHPLACE (County & State, ar fareign country) COUNTRY? during most of working life, even if retired INDUSTRY 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Address 16. SOCIAL SECURITY NO 17. INFORMANT requires that the death (Yes, no, or unknown) (If yes give wor or dates of service) INTERVAL BETWEEN TB. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).
PART I. DEATH WAS CAUSED BY: ONSET AND DEATH AKCINOMA 1100 IMMEDIATE CAUSE (o) Poge 4 may be retained by the haspitol ar ottending physician. DHE TO Conditions, if ony, which gave rise to immediate cause (o), DUE TO stating the underlying couse prior to TO FUNERAL DIRECTOR: After this certificate has been as the lost. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) director, page 3 should be detoched for use should be filed with the State Dept. of Health p YES E NO 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Month, Doy, Yeor 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (State) Haur o.m. factory, street, affice bldg., etc.) While Not While ot work ot work 21. I certify that (I) (this haspital) attended the deceased fram. 1965-10 . 1967, that (1) (we) last 12~28 3 should 1967, and that death accurred at 447M, fram causes and on the date stated above. 18 saw the deceased alive an. 22b. DATE SIGNED 22o. SIGNATURE ATTENDING STAFF PHYS. M.D. DIRECTOR PHYS 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY. 23o. BURIAL CREMATION 23b. DATE THEREOF 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) 25q. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR 20 M 1/66 min

48610 faring ferror almorated AND THE RESIDENCE OF THE PARTY 

MARYLAND STATE DEPART. NT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH be executed within 24 haurs after death death and 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) physician and campletely filled in by the funeral en please remave carban papers. Pages 1 and o. COUNTY b. COUNTY o. STATE Queen Anne's Maryland Wicomico MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 16 write RURAL and give nearest town) 27 days Grasonville Salisbury d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e. IS RESIDENCE ON A FARM? d. STREET ADDRESS Deer's Head State Hospital YES NO DE 3. NAME OF First Middle 4. DATE Month Lost Dov Year DECEASED (Type or print) OF DEATH 19 67 RUTH January May Grace 9. AGE (In years lost birthdoy) IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE 7. MARRIED 8. DATE OF BIRTH IF UNDER 1 YEAR NEVER MARRIED Months Dovs Hours WIDOWED X DIVORCED 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & Stote, or foreign country) during most of working life, even if refired) COUNTRY? **INDUSTRY** X ARYLAND requires that the death certificate 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ULIA WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. INFORMANT onville permit. (Yes, no, or unknown) (If yes give wor or dotes of service 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN signed by the burial-transit p ONSET AND DEATH CA of lung IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate couse (o), DUE TO stoting the underlying couse Page 4 may be retained by the haspital or attending TO FUNERAL DIRECTOR: After this certificate has been as the WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 3 shauld be detached far use with the State Dept. af Health YES [ NO 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (Stote) (County) 20c. TIME OF INJURY Month, Doy, Year Hour o.m. foctory, street, office bldg., etc.) Not While at work ot work 21. I certify that (1) (this haspital) attended the deceased fram December 12, 19 66, to January 1967 that (I) (we) lost sow the deceased glive an January 8 19 67, and that deoth occurred at 1012 M, from causes and an the date stated obave. 22b. DATE SIGNED 22o. SIGNATURE MED. DIRECTOR ATTENDING 1/9/67 bc. directar, page 3 shauld be filed v M.D. PHYS. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Deer's Head State Hospital, Salisbury, Md. Dr. L. V. Maldve 23o. BURIAL CREMATION. 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) (State) REMOVAL (Specify) HESTER FIELD 24 FUNERAL DIRECTOR 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE



## MARYLAND STATE DEPARTMENT OF HEALTH

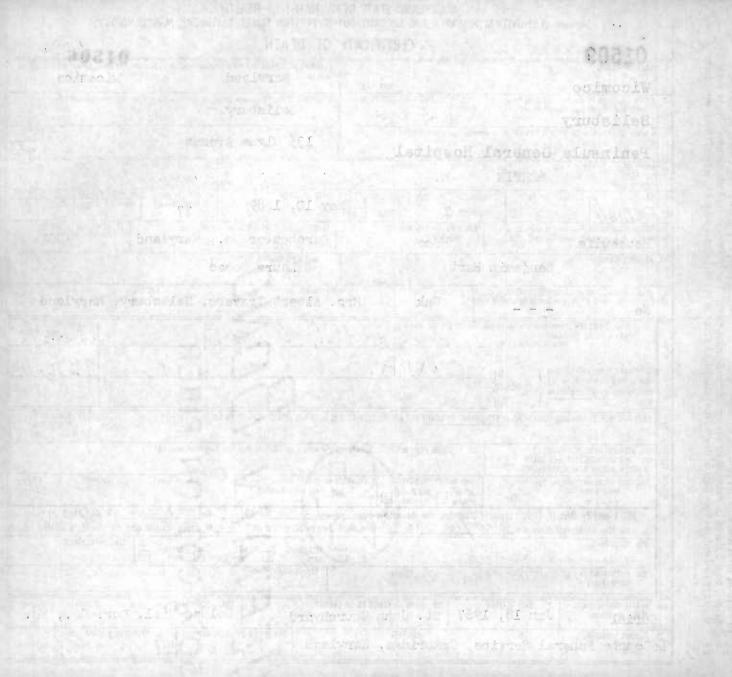
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1	01509 CERTIFICATE	OF DEATH
	1. PLACE OF DEATH  o. COUNTY  Wicomico  MARYLAND	2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission)     o. STATE Maryland
	b. CITY OR TOWN (If autside corparate limits, write RURAL and give nearest tawn)  Salisbury  c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside carporate limits, write RURAL and give neorest town) Salisbury
	d. NAME OF HDSPITAL DR INSTITUTION (If nat in haspital, give street address)  Peninsula General Hospital	d. STREET ADDRESS  135 Clyde Avenue  e. IS RESIDENCE ON A FARM2 YES NO. C.
	3. NAME OF DECEASED (Type or print)  BERTIE M. Middle M. SA	Last 4. DATE Manth Doy Year OF DEATH JANUARY 16 19 67
	FEMALE WHITE WIDOWED DIVORCED IN	B. DATE OF BIRTH  9. AGE (In years last pirthday) yrs.  11. BIRTHPLACE (Caunty & State, or foreign country)  12. CITIZEN OF WHAT
	100. USUAL OCCUPATION (Give kind of work done during most of working his even if retired)  10b. KIND OF BUSINESS OR INDUSTRY	Dorchester Co., Maryland COUNTRY? USA
	13. FATHER'S NAME  Benjamin Hart	14. MOTHER'S MAIDEN NAME Laura Booze  INFORMANT  Address
	(Yes, no, or unknown) (If yes give war or dotes af service) Unk Mrs	s. Albert Travers, Salisbury, Maryland
	1B. CAUSE OF DEATH (Enter anly one couse per line far (a), (b), and (c).)  PART I. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a)  DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  (c)	ial arest interval between onset and death
7	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO 1  200. ACCIDENT WAS UNDERLYING   200. ACCIDENT WAS UNDERLYING   20b. DESCRIBE HOW INJURY OCCURRED.   OR CONTRIBUTING   CAUSE OF DEATH   CAU	PERFORMED? YES NO
		(Enter noture of injury in Part I ar Part II of item 18.)
	Haur a.m.  While Nat While of wark	CE OF INJURY (Hame, farm, ary, street, office bldg., etc.)  20f. (City or town) (County) (State)
	21. I certify that (I) (this haspital) attended the deceased framsaw the deceased alive an19, and that	t death accurred at TAM, fram couses and an the date stated above.
	220. SIGNATURE  CULLE SEEW  M.I  22c. PHYSICIAN'S CARRT E HEAVN MD	D. ATTENDING MED. STAFF 22b. DATE SIGNED  PHYS. DIRECTOR PHYS.  22d. ADDRESS 2 6 N homos 80  Sales lun lu
	236. BURIAL (REMATION, BEMOVAL Specify)  23b. Date THEREOF Jen 23c. NAME OF CEMETERY OR St. John Chur	crematory Golden Hill, Dor. Co., Md.
)	24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Mary	yland 250. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAM 20 1967

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 shauld be detached far use as the burial-transit permit. Then please remave carbon papers. Pages 1 and 2 shauld be filed with the State Dept. of Health priar to burial, crematian, ar remaval, and in any event, within 72 haurs after death. VR A15 (4) 20 M 1/66

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death

Page 4 may be retained by the haspital ar attending physician.



301 W. PRESTON STREET, BALTIMORE 1, MARYLAND Items 1d.8.9 Film G385 5 1/24/67 mh ULDU (
I SIDENCE Where deceased lived, If institution, Residence before admission) Y. PLACE OF DEATH a. COUNTY b. COUNTY Wicomico a. STATE files. Wicomico Marvland MARYLAND ector. b. CITY OR TOWN (if outside corporata limits. c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL end give naerest town) write RURAL and give nearest town) Salisburv Parsonsburg d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street eddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Peninsula General Hospital YES X NO 3. NAME OF 4. DATE Month DECEMBED OF (Typa or print) DEATH 196 6. COLOR OR RACE 7. MARRIED NEVER MARRIED AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS last birthday) Months WIDOWED DIVORCED March 2, 1923 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foraign country) 10a. USUAL OCCUPATION (Giva kind of work 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) Housewife Own Home North Carolina USA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME PM Ada Wydell Grover C. Holloway 15. WAS DECEASED EYER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address (Yas, no, or unkown) | (Ifyasgive war or datas of sarvica) executed v Harold Scott 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). ONSET AND DEATH PART I. DEATH WAS CAUSED BY: hact shull - crushed Chest IMMEDIATE CAUSE (a) Office a DUE TO Conditions, if any, which (b) gava risa to immadiata causa DUE TO (a), slating the undarlying PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(8) 19. WAS AUTORSY CERTIFICATION PERFORMED? burial NO X 20b. DESCRIBE HOW INJURY OCCURED, (Enler natura of injury in Part I or Part II of item 18.) 20a. EXTERNAL CAUSE WAS PRIMARY & or CONTRIBUTING writing to Chief A Page 3 sl CAUSE OF DEATH. MEDICAL 20d. INJURY OCCURRED. 20e. PLACE OF INJURY (Homa, farm, factory, street, office bldg., etc.) Whila Not Whilad at work at work OR: certificate srded to the DIRECTOR: 21. I certify that I took charge of the remains described above, held an Autopsy | Inspection X Inquiry and in my opinion death resulted from: Natural causes Accident X. Suicide Undetermined manner Homicide CHIEF MEDICAL EXAMINER ACTUAL please executed should be to FUNERAL I Health or its de ASSISTANT MEDICAL EXAMINER DATE SIGNED SIGNATURE DEPUTY MEDICAL EXAMINER NAME (Typa) Address (Street, city, town, or county) 22c. NAME OF CEMETERY OR CREMATORY 22a, BURIAL, CREMATION, 22b. DATE THEREOF 22d. LOCATION (City, town, or country) REMOVAL (Specify) Pansons 24a. REC'D BY REGISTRAR | 24b. REGISTRAR'S SIGNATURE VR A15ME quelle Sel DATS AN 5M 1/62

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) 1. PLACE OF DEATH is necessary, lirector. Page your files. a. COUNTY Ö - STATE b. COUNTY Wicomico MARYLAND Maryland Wicomico Popl b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) Salisbury WKS. Salssbury d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? after retained he State YES NO Evergreen Ave. Evergreen Ave 3. NAME OF Middle DATE Year DECEASED OF (Type or print) DEATH 1967 Thomas Henderson Sergeant
B. DATE OF BIRTH January 1, 2, and 3 to age 5 may be and 2 with 1 6. COLOR OR RACE 7. MARRIED NEVER MARRIED Y AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months Hours WIDO WED Male DIVORCED White December 6 10a. USUAL OCCUPATION (Giva kind of work Give Pages 1, 2 10b. KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY? dona during most of working life, avan if ratirad) pages y event NONE NONE Maryland

14. MOTHER'S MAIDEN NAME U.S.A. 13. FATHER'S NAME ing" in pencil in Item 18. Give in's Office along with form P. s a burial-transit File Charles D. Sergeant, Jr.

15. WAS DECEASED EVER IN U.S. ARMED PORCES? | 16. SOCIAL SECURITY NO. Marjorie Anne 2 17. INFORMANT (Yes, no, or unkown) | (Ifyesgiva war or datasofsarvice) NONE C.D. Sergeant, Jr. See #2 18. CAUSE OF DEATH [Enter only one cause par line for (e), (b), end (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Interstitial Pneumonitis IMMEDIATE CAUSE (a) Hours DUE TO Conditions, if any, which (b) "pending" gave rise to immediate causa Examiner DUE TO (a), stating the undarlying causa last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(8): 19, WAS AUTOPSY CERTIFICATION writing the word 'e Chief Medical Ex Page 3 should be PERFORMED? EXAMINER: This NO 20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Pert II of item 18.) PRIMARY | or CONTRIBUTING | CAUSE OF DEATH. Sudden death in infancy. 20d. INJURY OCCURRED 20o. PLACE OF INJURY (Home, farm, 20c. TIME OF INJURY Month, Day, Year 20f. (City or town) (County) (Sleta) fectory, street, office bldg., etc.) Not Whila Hour a.m. While at work at work p.m. 0 0 21. I certify that I took age of the remains described above, held an Autopsy A Inspection Inquiry and in my opinion arded DIRECT death resulted from: tural causes X Accident Suicide Homicide Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL should be n. FUNERAL ASSISTANT MEDICAL EXAMINER SIGNATURE January 30, 1967 DEPUTY DEPUTY MEDICAL EXAMINER 0 EXAMINER'S Earl L. Royer Address (Street, city, town, or county amden Ave. Salisbury, Md M.D. NAME (Type) ealth 22e. BURIAL, CREMATION, 22b. 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or country) (State) REMOVAL (Specify) 940 I B urial Wicomico Memorial Park Salisbury, Maryland 23. FUNERAL DIRECTOR **ADDRESS** 24a. REC'D BY REGISTRAR | 24b. REGISTRAR'S SIGNATURE VR A15ME Hill Funeral Salisbury, Maryland 5M 1/62 Home

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 01512 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DERT. 2. USUAL RESIDENCE (Where deceased lived, if institution, Ruston) before admission PLACE OF DEATH a. COUNTY a. STATE b. COUNTY delay is and 3 ta Wicomico Maryland Worcester af MARYLAND after death partment C LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) Ocean City d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? haurs 203 N. Second St. DOA Peninsula General Hospital NO T 8. Give Pages First Middle 3. NAME OF Last 4. DATE Month Year within 72 DECEASED he MICHAEL VICTOR SHAFFER 1-17-67 19 (Type or print) DEATH with AGE (In years last birthday) S. SEX B. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 6. COLOR OR RACE 7. MARRIED NEVER MARRIED Days 2-19-64 Male White WIDOWED DIVORCED event and 11. BIRTHPLACE (State or fareign country) 10a. USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? INDUSTRY DALISBURI Aud 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME This certificate shauld be executed within = FIE and 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT (Yes, no. ar unknown) ((If yes give war or dates of service ar remayal. 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: burial-transit Interstitial pneumonitis IMMEDIATE CAUSE (a) writing the ward crematian, DUF TO Conditions, if any, which gave rise to immediate cause (a). DUF TO stoting the underlying couse last. OS buriol, 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) YES 🛣 NO the certificate. 20g. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) agent, priar shauld PRIMARY ar CONTRIBUTING CAUSE OF DEATH. 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or tawn) (County) (State) 20c. TIME OF INJURY Manth, Day, Year factory, street, affice bldg., etc.) Not While may be retained far yaur FUNERAL DIRECTOR: Page at work designated 21. I certify that I took charge of the remains described above, held an Autapsy 17. Inspection K Inquiry X ond in my opinion the funeral director. deoth resulted from: Natural causes X Accident Suicide 7 Homicide Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE January 20, 1967 O DEPUTY L. Royer, M DEPUTY MEDICAL EXAMINER [ Health 409 Camden Ave., Salisbury, Md. NAME (Type) Address (Street, city, town, or county) 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23a. BURIAL, CREMATION, 23b. DATE THEREOF (County) (State) 50 REMOVAL (Specify) SUNSET JALIN 24. FUNERAL DIRECTOR 2Sa. REC'D BY REGISTRAR VR A15ME (5 Funeral Home, Berlin, Md. Burbage

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 01510 01513 death executed within 24 hours after death 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH O. COUNTY WICOMICO attending physicial and completely filled in by the fur permit. Then please canave carbon papers. Pages 1 on, or removal, and in ony event, within 72 hours ofter c. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest tawn) MARYLAND b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn)
Salisbury c. LENGTH OF STAY IN 1b Snow Hill e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS Peninsula General Hospital Federal YES NO 3. NAME OF DATE Month Year Day DECEASED TANUARY 19 6 DEATH (Type ar print) S. SEX 6. COLOR OR RACE DATE OF BIRTH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 7. MARRIED NEVER MARRIED last birthdoy) Manths Days Hours 2 WIDOWED DIVORCED remake arch 9 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or fareign country) during most of working life, even if retired) COUNTRY? INDUSTRY requires that the death certificate Seanstress Snow Hill. SSMIKER 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME cremotion, or removal. 16. SOCIAL SECURITY NO INFORMANT Address WAS DECEASED EVER IN U.S. ARMED FORCES? permit. (Yes, na, or unknown) ((If yes give war or dates of service) INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) signed by the burial-transit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY CERREBRAL IMMEDIATE CAUSE (a) Poge 4 may be retained by the hospital or ottending physician. DUF TO burial. TLEO- COLIC INTUSS EPTTIN Conditions, if ony, which gove rise to immediate cause (a), DUE TO stating the underlying cause os the last. WAS AUTOPSY PERFORMED? has PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) of Heolth er this certificate has YES [ NO 20g. ACCIDENT WAS UNDERLYING 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or tawn) (County) (State) 20c. TIME OF INJURY Month, Day, Year Haur a.m. factory, street, office bldg., etc.) While Not While at wark at wark for FUNERAL DIRECTOR: After director, page 3 should be of 1967 10/ 19 6 7 that (1) fwe) last 21. I certify that (1) (this haspital) attended the deceased from 19 67, and that death accurred at 6 4 M, from causes and on the date stated abave. saw the deceased alive an 22b. DATE SIGNED 22a. SIGNATURE ATTENDING M.D. PHYS. DIRECTOR PHYS. director, page should be filed 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 23a. BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) Surial 24. FUNERAL DIRECTOR 25b REGISTRAR'S SIGNATURE VR A15 (4) 20 M 1/66

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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death and death		PLACE OF DEATH	2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
r deat uneral l and er deat		o. COUNTY Wicomico MARYLAND	o. STATE Maryland b. COUNTY Talbot
irs after y the fur Pages 1 urs after		b. CITY OR TOWN (If outside corporate limits.   c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest town)
by the Page		write RURAL and give neorest town) Salisbury 34 days	Tilgman 20.2
hours in by rrs. Po 2 hour		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress)	d. STREET ADDRESS  e. IS RESIDENCE ON A FARM?
law requires that the death certificate be executed within 24 hours after death nating physician.  been signed by the attending physician and completely filled in by the funeral is the burial-transit permit. Here please remove carban papers. Pages I and is the burial, crematian, or removal, and in any event, within 72 hours after death.		Deer's Head State Hospital	YES NO Z
ithiin y fi		NAME OF First Middle DECEASED	Last 4. DATE Month Doy Year
ecuted withit completely fove carban y event, with		(Type or print) Martha Ann S	INCLAIR DEATH January 22 19 01
omp ve c	S.	1. Market	8. DATE OF BIRTH 9. AGE (In years   IF UNDER 1 YEAR   IF UNDER 24 HRS.
execution complete co		emale White WIDOWED DIVORCED	9/15/1880 80 yrs.
and and e rem	10o	. USUAL OCCUPATION (Give kind of work done ina prost of working life Jeven if retired)  10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & Stote, or foreign country)  12. CITIZEN OF WHAT
icate b sician please , and i	_	Housework	Talbot Maryland (15)?
iffice si liffice	13.	FATHER'S NAME	14. MOTHER'S MAIDEN NAME Rebecca L. (ummings
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eath nit. or re		s no or unknown) Illf was give wor or dates of service	INFORMANT Address
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that the dian.  by the attransit pen		18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).) PART I. DEATH WAS CAUSED BY:  To box programs:	, lower lobe left lung INTERVAL BETWEEN ONSEI AND DEATH 2 CLYS
quires that the physician. signed by the burial-transit burial, cremat		MMEDIATE CAUSE (o) LODGE PREMIOTICA	, lower lobe left lung 2 days
quires the physician signed by burial-train ourial, cre		Conditions, if ony, which gove )	
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w re ding een the r to		stoting the underlying couse (c)	
AN: The law rall or attending icate has been for use as the Health prior to		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO	THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS AUTOPSY PERFORMED?
traffe e has use a	TION	Arteriosclerotic heart disease	PERFORMED?
IAN: 1 tal or ficate for us f Healt	IFICA		. (Enter noture of injury in Port I or Port II of item 18.)
二年 生工生	MEDICAL CERTIFICATION	OR CONTRIBUTING □ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
s PHYSIC the hospi this certi detached e Dept. o	SIG	20c. TIME OF INJURY Month, Doy, Yeor 20d. INJURY OCCURRED 20e. PL	ACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote)
	MED	Hour o.m.  p.m.  19  While Not While of work of work	ctory, street, office bldg., etc.)
ATTENDING stained by th CTOR: After th should be de			December 19, 1966, to January 22, 1967, that (I) (we) last at death accurred at 12:10AM, fram causes and an the date stated above.
R: A		saw the deceased alive an anuary 22 1967, and the	
OR ATTENI be retained DIRECTOR: A ie 3 should ed with the		220. SIGNATURE	ATTENDING MED. STAFF TO 1/22/67
OR report of the second of the			A.D. PHYS. DIRECTOR PHYS. XI 1/23/67
TO HOSPITAL OR ATTEN Page 4 may be retained TO FUNERAL DIRECTOR: director, page 3 should should be filed with the		22c. PHYSICIAN'S NAME (Type) Dr. L. V. Maldve	Deer's Head State Hospital, Salisbury, Md
O HOSPI Page 4 r O FUNER director, should t	230	D. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR	CREMATORY 23d_ LOCATION (City or Town) (County) (Stote)
Sho dire		RAMOVAL(Specify) 1/25/1967 Sherwood	
	24	FUNERAL DIRECTOR ADDRESS	2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE
VR A15 (4) 20 M 1/66		MAURICE E. NEWNAM & SON, EASTON, M	DATE JAN 25 1967 Icharles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 01512 01515 CERTIFICATE OF DEATH requires that the deoth certificate be executed within 24 hours after death. and completely filled in by the funeral remove carban papers. Pages 1 and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission) a. COUNTY b. COUNTY Wicomico Maryland Talbot MARYLAND b. CITY OR TOWN (If autside carparate limits, C. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) write RURAL and give nearest tawn) Oxford Dec. 16.1966 Salisbury IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS Pine Bluff State Hospital Box 404 YES NO NO 4. DATE 3. NAME OF First Middle Last Month Year Day DECEASED Joseph Thomas Upshur January (Type ar print) DEATH 9. AGE (In years IF UNDER 1 YEAR 5. SEX 7. MARRIED DE 8. DATE OF BIRTH IF UNDER 24 HRS 6. COLOR OR RACE **NEVER MARRIED** lost birthday) Manths Days Haurs male colored WIDOWED DIVORCED July 24. 1906 10o. USUAL OCCUPATION (Give kind of work done 12. CITIZEN OF WHAT 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) during most of working life, even if retired) INDUSTRY COUNTRY? Ferry Boat Deck Hand Talbot Co., Md. 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Joseph Thomas Katie Morris the attending part and a sit permit. The 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Records of Pine Bluff State (Yes, no, or unknown) (If yes give wor or dotes of service) buriol, crematian, or 218-10-0240 Hospital, Salisbury, Maryland no INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).) signed by the buriol-transit p ONSET AND DEATH unknown PART I. DEATH WAS CAUSED BY: carcinoma of lung IMMEDIATE CAUSE (a) DUE TO Conditions, if ony, which gave rise to immediate cause (a), DUE TO stating the underlying couse by the haspital ar attending TO FUNERAL DIRECTOR: After this certificate has been as the TO HOSPITAL OR ATTENDING PHYSICIAN: The law Page 4 may be retained by the haspital ar attendin lost. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) CERTIFICATION of Health NO YES 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City ar town) (County) (State) 20c. TIME OF INJURY Month, Day, Year factory, street, office bldg., etc.) Nat While at wark 2). I certify that Af (this haspital) ottended the deceased from Dec. 16, 1966, to Jan. 7, 1967, that the (we) last saw the deceased olive on Jan. 7 19 67, and that death occurred at 15 M, from couses and on the date stated above. 22a. SIGNATURE 22b. DATE SIGNED STAFF PHYS. ATTENDING × Jan. 9, 1967 M.D. DIRECTOR 22d. ADDRESS Pine Bluff State Hospital 22c. PHYSICIAN'S NAME (Type) P. Ritchings, M.D. Salisbury, Maryland director, shauld by 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23b. DATE THEREOF (County) (State) 23a. BURIAL, CREMATION, BREMOYAL (Specify) Jan. 12, 1967 Streamersville Cemeterv Oxford, Talbet Ml. Dashiell Funeral Heme, Dever St, Easten, Mi. 2Sb. REGISTRAR'S SIGNATURE 2Sa. REC'D BY REGISTRAR Charles VR A15 (4) 20 M 1/66

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 01513 and 2 death. death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. CDUNTY b. COUNTY by the fages 1 ars after Wicomico MARYLAND Maryland Wicomico CITY OR TOWN (if outside corporate limits, write RURAL and give nearast town) c. LENGTH OF STAY IN 1b c. CITY DR TDWN (If outside corporate limits, write RURAL and give nearest town) etely filled in by the bon papers. Page within 72 hours a hours dd, 2430 days Salisbury Salisbury d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? NO Deer's Head State Hospital Salisbury Md. YES Union Road within etely completely ve carbon event, with 3. NAME OF Last DATE Middle 4. Month Day Year DECEASED AGE (in years | FUNDER 1 YEAR | FUNDER 24 HRS. last birthday) | Months | Days | Hours | Min. (Type or print) DEATH Esther Toadvine 5. SEX 6. CDLOR OR RACE 8. DATE OF BIRTH remove 7. MARRIED NEVER MARRIED any and Female White DIVORCED | Feb. 12, 1887 WIDDWED 10 10a. USUAL OCCUPATION (Give kind of work done) = 10b. KIND DF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT been signed by the aftending physician the burial-transit permit. Then please in to burial, cremation, or removal, and in death certificate be during most of working lifa, even if retired) COUNTRY? INDUSTRY at home Wicomico County, Maryland USA 13. FATHER'S NAME 14. MDTHER'S MAIDEN NAME Alfred P. Toadvine Margaret Esther Brown 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SDCIAL SECURITY ND. (Yes, no, or unkown) | (If yes give war or dates of service) Mrs. Nellie T. Wimbrow (Sister) No 106 W. Locust St., Salisbury, Maryland INTERVAL BETWEEN ONSET AND DEATH 2 WKS. 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: Bilateral bronchopneumonia attending physician. IMMEDIATE CAUSE (a) DUKAUK Conditions, If any, which Hypertensive arteriosclerotic cardiovascular Years gave rise to Immediate DUE TO disease. cause (a), stating the as th underlying cause last. has After this certificate had be detached for use a State Dept. of Health pi CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY 19. PERFORMED? NO X YES | the hospital PHYSICIAN: 20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NDTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) N/A 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, (State) 20f. (City or town) (County) factory, street, office bldg., etc.) Hour a.m. Not While ATTENDING p.m. at work at work DIRECTOR: Af age 3 should I lied with the S retained 1/12 21. I certify that (I) (this hospital) attended the deceased from. 19.60 to 19.67 that (I) (we) last 67 and that death occurred at 1:15. from the causes and on the date stated above. saw the deceased alive on 22a. SIGNATURE 22b. DATE SIGNED ATTENDING STAFF PHYS. DIRECTOR M.D. PHYS. 4 may HOSPITAL director, pa should be fil PHYSICIAN'S 22d. ADDRESS NAME (Type) L. V. Maldve. M. D. Head State Hospital, Salisbury, Md. Deer's BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) Burial John's Cemetery Fruitland. Maryland FUNERAL DIRECTOR 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE Melanles 1967 HOLLOWAY & COMPANY, SALISBURY, MARYLAND VR A15 (4) 20M 1/65

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MARYLAND STATE DEPARTMENT OF HEALTH
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1 (1/1)		MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 212	201
2 2 2		01517 CERTIFICATE OF DEATH 015	
ours after death.  by the funeral  Pages I and 2 hours after death.		PLACE OF DEATH  2. USUAL RESIDENCE (Where deceased lived, if institution: Residen 5. COUNTY 5. COUNTY 6. STATE 7. COUNTY	nce before admission)
n 24 hours of the state of the		write RURAL ond give neorest town) Salisbury  I 2yrs. 9 mos. Salisbury  d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress)  Deer's Head State Hospital  Route #1	e. IS RESIDENCE ON A FARM? YES NO
be executed within 24 hours after death and completely filled in by the funerol remove carbon papers. Pages 1 and 2 in any event, within 72 hours after death	S.	NAME OF DECEASED (Type or print)  NAME O	Days Hours Min.
age re nd in	13.	USUAL OCCUPATION (Give kind of wark dane ing most of working life, even if retired)  House Work  FATHER'S NAME  10b. KIND OF BUSINESS OR INDUSTRY  Richmond, Virginia  11c. BIRTHPLACE (County & State, or fareign country)  Richmond, Virginia  11d. MOTHER'S MAIDEN NAME  Mary Jane Unk)	TIZEN OF WHAT JUNTRY? SA
thot the deoth cerion.  I by the attending propositionsit permit. The cremotion, or remo	1S. (Ye	WAS DECEASED EVER IN U.S. ARMED FORCES? s. no. or unknown) (If yes give wor or dotes of service)  16. SOCIAL SECURITY NO.  17. INFORMANT Walter C. Tomlin (Son)  Box 443. Fruitland, Maryland  18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	INTERVAL BETWEEN
physic signed buriol buriol,		PART I. DEATH WAS CAUSED BY:    MMEDIATE CAUSE (o)   Broncho-Pneumonia	Several weeks
V: The or after or the has or use or solth pr	IFICATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)  200, ACCIDENT WAS UNDERLYING 205, DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)	19. WAS AUTOPSY PERFORMED? YES NO
PHYSICI e hospite his certif stached i Dept. of	MEDICAL CERTIFICATION	Haur o.m.  P.m.  While Not While of work factory, street, office bldg., etc.)	unty) (State)
TO HOSPITAL OR ATTENDING Poge 4 moy be retained by th TO FUNERAL DIRECTOR: After the director, page 3 should be de should be filed with the State		Halle St Clinica and M.D. PHYS. DIRECTOR PHYS. D. 1/1	he date stated above the signed are signed a
TO HOSP Poge 4 To FUNE should		BURIAL (REMATION, REMOVAL (Specify) Burial  Jan. 11,1967  Wicomico Memorial Park  Salisbury, Maryl  FUNERAL DIRECTOR  HOLLOWAY & COMPANY, SALISBURY, MARYLAND  Date 18,21,10,4067	SIGNATURE

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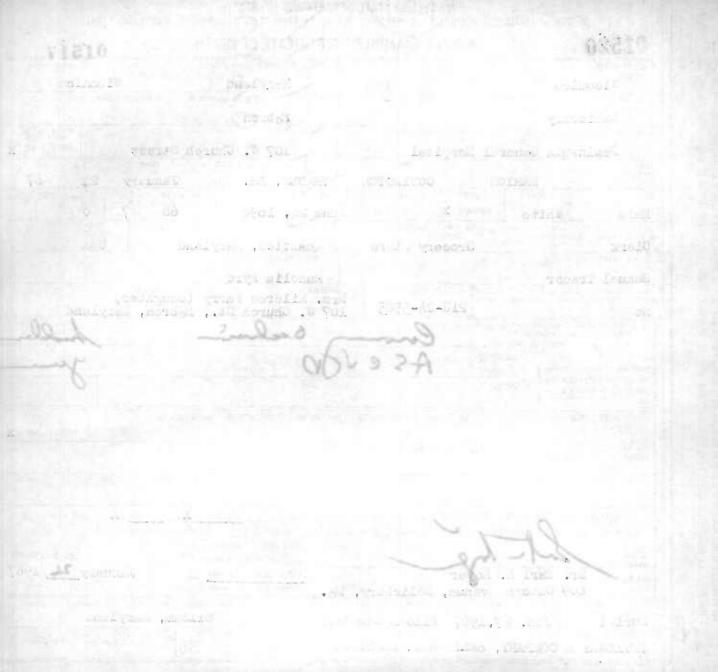
W. PRESTON STREET, BALTIMORE 1. MARYLAND US AL RESIDENCE (Where decessed lived, If institution: Residence before admission) PLACE OF DEATH e. COUNTY b. COUNTY Wicomico MARYLAND Marvland Wicomico b. CITY OR TOWN (if outside corporate limits. c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporete limits, write RURAL end give neerest town) write RURAL and give neerest town) Salisbury Parsonsburg d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street eddress) d. STREET ADDRESS IS RESIDENCE ON A FARM? YES W NO Peninsula General Hospital Stat 3. NAME OF Middle Lasl 4. DATE Month Year DECEASED OF (Type or print) DEATH 6. COLOR OR RACE 7. MARKED B. DATE OF BIRTH IF UNDER 24 HRS. AGE (In years | IF UNDER 1 YEAR NEVER MARRIED lest birthday) Months Hours WIDOWED DIVORCED Nov. 10b. KIND OF BUSINESS OR INOUSTRY | 11. BIRTHPLACE (Stelle or foreign country) 10a. USUAL OCCUPATION (Give kind of work 12. CITIZEN OF WHAT COUNTRY? nould be executed within 24 hours aft "in pencil in Item 18. Give Pages 1, 2 Office along with form PM3. Page done during most of working life, even if retired Housewife Own Home Maryland USA File pages 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Vera Holloway Harold Scott 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address (Yes, no, or unkown) | (Ifyes give wer or detes of service) Townsend Parsonsbufg. 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), end (c). INTERVAL BETWEEN burial-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1 mediate DUE TO should 0 Conditions, if env. which (b) "pending" O Examiner's geve rise to immediate cause OUE TO should be used as (a), steting the underlying PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO GEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(10) 19. WAS AUTOPSY CERTIFICATION PERFORMED writing the word Chief Medical NO 200. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURED. (Enler neture of injury in Pert I or Pert II of item 18.) 0 10 5 20c. TIME OF INJURY Month, Dey, Year 20d. INJURY OCCURRED. 20e. PLACE OF INJURY (Home, farm, ; 20f. (City or town) (County) (Stete) fectory, street, office bldg., etc.) While Not While et work et work DIRECTOR: 1 21. I certify that I took charge of the remains described above, held an Autopsy Inspection X Inquiry and in my opinion designated Accident X Undetermined manner death resulted from: Natural causes Suicide Homicide CHIEF MEDICAL EXAMINER ACTUAL lease execut should be for FUNERAL DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE DEPUTY DEPUTY MEDICAL EXAMINER 0 EXAMINER'S NAME (Type) Address (Street, city, town, or county) please 4 shoul O FUN 22c. NAME OF CEMETERY OR CREMATORY 22e. BURIAL, CREMATION. 22b. DATE THEREOF 22d. LOCATION (City, town, or country) (Stete) REMOVAL (Specify) Salisbury, Burial Farsons 24e. REC'O BY REGISTRAR | 24b. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR VR A15ME DATE JAN 5M 1/62

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ARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH REPT 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before edinission a. COUNTY Wicomico b. COUNTY Wicomico Maryland MARYLAND b. CITY OR TOWN (if outside corporate limits. c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) director. write RURAL and giva nearest town) Salisbury Salisbury d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) d. STREET ADDRESS . IS RESIDENCE the funeral retained fo he State Do ON A FARM? 315 Martin Street Peninsula General Hospital YES NO K 3. NAME OF 4. DATE Middle to the DECEASED Edward Townsend Lee DEATH January 1967 (Type or print) 6. COLOR OR RACE 7. MARRIED X NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS last birthday) White Months Hours WIDOWED June 9. 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY done during most of working life, even if ratirad) Construction Maryland USA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Eddie Townsend Lillie Collins 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 16. SOCIAL SECURITY NO. 17. INFORMANT Martin St. ' in pencil in Item 18. Office along with for Mrs. Ethel L. Townsend Salisbury, Md. yes 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). INTERVAL BETWEEN or removal, burial-fransit PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which cremation, gava risa to immediata cause Medical Examiner's be used as a "pending" DUE TO (a), stating the undarlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY CERTIFICATION agent, prior to burial, PERFORMED? ease execute the certificate, writing the word should be forwarded to the Chief Medical E FUNERAL DIRECTOR: Page 3 should be YES TO NO 200. EXTERMAL CAUSE WAS PRIMARY OF CONTRIBUTING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injugy in Part I of Part II of item 18. CAUSE OF DEATH. WEDICAL 20c. TIME OF INJURY 20d, INJURY OCCURRED | 200 PLACE OF INJURY (Homa, farm, 20f. (City or town) (County) (State) factory\_straat, office bldg., etc.) While Not While at work at work 21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inqui and in my opinion DICAL Undetermined manner death resulted from: Natural causes Accident Suicide Homicide CHIEF MEDICAL EXAMINER ACTUAL ASSISTANT MEDICAL EXAMINER DATE SIGNED DEPUTY MEDICAL EXAMINER ō Address (Street, city, town, or county) NAME (Typa) Health 22a. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) REMOVAL (Specify) ₽40 Salisbury Buria Parsons Cemetery 23. FUNERAL-DIRECTOR ADDRESS 24a. REC'D BY REGISTRAR | 24b. REGISTRAR'S SIGNATURE VR A15ME Salisbury, 5M 1/63 ace

The man of the first term and the man of the state of the

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01520 FOR STATE HEALTH DEPT: 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission PLACE OF DEATH a. COUNTY Wicomico b. COUNTY 2, and 3 to PM3. Page Department of Wicomico Mary land MARYLAND c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) b. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 1b. after . Habron Salisbury d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e. IS RESIDENCE ON A FARM? d. STREET ADDRESS haurs Item 18. Give Pages 1, State 107 W. Church Street NO T Peninsula General Hospital Middle DATE Year 3 NAME OF DECEASED 1967 COVINGTON MARION TRADER. SR. January within DEATH (Type ar print) IF UNDER 1 YEAR IF UNDER 24 HRS. DATE OF BIRTH 9. AGE (In years 6. COLOR OR RACE S. SEX 7. MARRIED NEVER MARRIED lost birthday) 68yrs. Months Days Hours June 24, 1898 WIDOWED X DIVORCED White hours Male and 2 11. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR during mast of warking life, even if retired) COUNTRY? INDUSTRY Quantico, Maryland USA dny Clerk Grocery Store pages 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME = Samuel Trader Manolia Byrd File puc 16 SOCIAL SECURITY NO. Mrs. Mildred Parry (Daughter) 15. WAS DECEASED EVER IN U.S. ARMED FORCES? permit. (Yes, na, ar unknown) (If yes give war or dates af service ward "pending" the Chief Medical ar remayal, 218-24-5985 107 W. Church St., Hebron, Maryland No 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) writing the ward certificate shauld burial, cremation, DUE TO Canditians, if any, which gave rise ta immediate cause (a), DUE TO stating the underlying cause D nsed WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) please execute the certificate. pe 20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) agent, prior shauld PRIMARY | ar CONTRIBUTING | 4 should EDICAL EXAMINER: CAUSE OF DEATH. MEDICAL 20e. PLACE OF INJURY (Hame, farm, (City ar tawn) (County) (State) 20d. INJURY OCCURRED 20c. TIME OF INJURY Manth, Day, Year foctory, street, office bldg., etc.) Hour a.m. Nat While far yaur may be retained tar yaur FUNERAL DIRECTOR: Page at wark at wark designated Inquiry X 21. I certify that I took charge of the remains described above, held an Autapsy Inspection K and in my apinian Matural causes Accident Suicide Homicide Undetermined manner the funeral director. death resulted from be retained CHIEF MEDICAL EXAMINER 22. DATE SIGNED ACTUAL ASSISTANT MEDICAL EXAMINER SIGNATURE January 24/1967 O DEPUTY Earl L. Royer DEPUTY MEDICAL EXAMINER Dr. Health ar FXAMINER'S Address (Street, city, town, or county) NAME (Type) 409 Camden Avenue. Salisbury, Ma. 23d. LOCATION (City or Town) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (County) (State) 23a. BURIAL, CREMATION, 0 Burial (Specify) Siloam, Maryland Jan. 27,1967 Siloam Cemetery REGISTRAR'S SIGNATUR 2So. REC'D BY REGISTRAR 2Sb. 24. FUNERAL DIRECTOR & COMPANY, SALISBURY, MARYLAND VR A15ME ( HOLLOWAY 6M 1/66



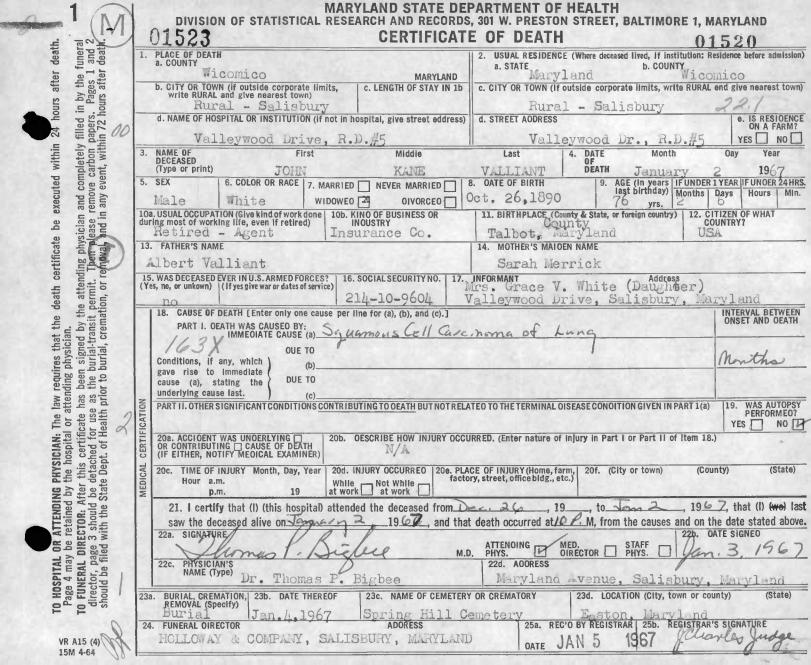
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 01521 01518 OF DEATH CERTIFICATE requires that the death certificate be executed within 24 hours after death 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) and completely filled in by the funeral gremove carbon popers. Pages, ond th any event, within 72 hours after bear PLACE OF DEATH o. COUNTY o. STATE Wicomico Wicomico MARYLAND Marvland b. CITY OR TOWN (If outside corporate limits, write RURAL and give necrest town)
Salisbury c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mons. Pittsville d. STREET ADDRESS e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sp. Hill Rr. Sani. Old Rt.# 50 YES NO TO 3. NAME OF Middle 4 DATE Month Year First Lost Doy DECEASED JOHN KEECH TRUITT 19 67 DEATH (Type or print) 9. AGE (In years birthdoy) IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE 7. MARRIED X 8. DATE OF BIRTH NEVER MARRIED 1880 dse remove Months Dovs Hours 3-30-1967 Male White WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & Stote, or foreign country) COUNTRY? during most of working life, even if retired) **INDUSTRY** physician nen please Retired Farmer Owner Wic. Maryland II S A 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME remova Eliha James Truitt Mary Ann Wimbrow IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dotes of service) Mrs. Janie F. Truitt, Sec 2 No INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per time for (o), (b), ond (c).) ardio rascular Reval d buriol-tronsit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) signed by DUE TO buriol, Conditions, if ony, which gove rise to immediate couse (o), DUE TO stoting the underlying couse the hospital or ottending TO FUNERAL DIRECTOR: After this certificate has been os the 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) CERTIFICATION for use of Heolth NO 🔀 20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) detached (IF EITHER, NOTIFY MEDICAL EXAMINER Dept. 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. foctory, street, affice bldg., etc.) Not While ot work at work 19 6, that (I) (we) lost 21. 1 certify that (1) (this hospital) attended the deceased from TO HOSPITAL OR ATTEND Poge 4 may be retained 19 $\frac{67}{7}$ , and that death occurred at  $\frac{9-P}{P}M$ , fram causes and an the date stated obove. saw the deceased alive an\_ 22b. DATE SIGNED 22o. SIGNATURE ATTENDING STAFF 1-25-1967 M.D. DIRECTOR PHYS. PHYS. director, poge should be filed 22d. ADDRESS 22c. PHYSICIANS Philip A. Insley Salisbury, Maryland Dr. NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION, 23b. DATE THEREOF (County) (Stote) REMOVAL (Specify)
Burial Salisbury, Wicomico, Maryland -25-1967 Parsons Cemetery 2Sb. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR **ADDRESS** lianter VR A15 (4) Hill Funeral Home 26 Salisbury, Maryland 1967 20 M 1/66

Momon T. Baker

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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requires that the death certificate be executed within 24 hours after death g physician.  signed by the attending physician and campletely filled in by the funeral e burial-transit permit. Then please remave carban papers. Pages 1 and 3 a burial, crematian, arremanal, and in any event, within 72 hours after death		d. NAME OF HOSPITAL OR INSTITUTION. (If hot in haspite	give street oddress)	d. STREET ADDRESS 612 Snith	15%	e. IS RESIDENCE ON A FARM? YES NO S
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equires that the dea physician. signed by the attenc burial-transit permit burial, crematian, an		1B. CAUSE OF DEATH (Enter only one cause per line PART I. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a)		I the payore	es-	ONSET AND DEATH
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PHYSICIAN: The law re the haspital ar attending this certificate has been letached for use as the Bept. of Health priar to		OR CONTRIBUTING □ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		Enter noture of injury in Part I or Port II		
Q + - 0 =	MEDICAL	Haur a.m. W p.m. 19 of v	hile Not While facto	ory, street, office bldg., etc.)	ity ar tawn) (Caun	
= 77 - 70		21. I certify that (I) (this hospital) att	ended the deceosed from 2019 <i>66</i> , and that	//- 9 , 19 66 ta death occurred at // 2 M, f	rom causes ond on the	
		220. SIGNATURE  Traibert R. Ith	ITE, M.O	ATTENDING MED. PHYS. DIRECTOR DIRECTOR DIRECTOR	STAFF PHYS. D	3-67
O HOSPITAL Page 4 may O FUNERAL I director, pag shauld be fil	230	NAME (Type) SUBERT K. D. BDRIAL, CREMATION, 23b. DATE THEREOF	WHITE, JR.	PRINTERY 23d 10CAT	ION (City of Town)	eunty) , Stote)
TO HOSP Page 4 1 TO FUNES director shauld	96	SMOVE (Specify) 1/3/1967	7 PARSONS CO	ENETERY SAL 25%, REC'D BY REGISTRAR	25b. REGISTRAR'S SIG	no.
VR A15 (4) 20 M 1/66		Deschil Hiel - Sale	stuy md	- DATE JAN 5	1967 Julia	rles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01524

CERTIFICATE OF DEATH

01521

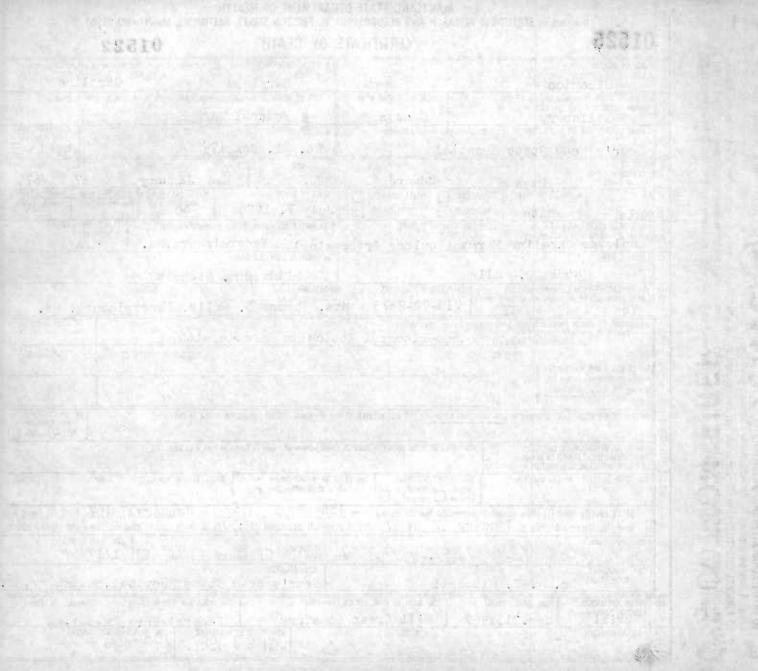
uneral Land er death		PLACE OF DEATH	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence befare admission)
3-4-		d. COUNTY WICOMICO MARYLAND	a. STATE Maryland b. COUNTY Wicomico
y the f Pages urs affe		b. CITY OR TOWN (If autside carparate limits, c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn)
by t Pa ours		write RURAL and give nearest town) Salisbury	Salisbury
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physician and campletely filled en please remave carban pape aval, and in any event, within 7.		Peninsula General Hospital	Riverside Drive
vith vith	3.	NAME OF First Middle	Last 4. DATE Manth Day Year
arbo arbo ar, v		OFCEASED (Type or print) Alice LANDIS We	EAUER DEATH JANUARU 26 1967
mpl ever	S.	SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 5	3. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months Days Hours Min.
a ca may	1	Female White WIDOWED   DIVORCED   ]	May 1, 1875   last birthday)   Months   Days   Hours   Min.
and in a	100	I. USUAL OCCUPATION (Give kind of work dane lips mast of working life, even if retired)	11. BIRTHPLACE (Caunty & State, ar foreign country)  12. CITIZEN OF WHAT
ease and		louse-Wife	Lancaster, Pa. USA
al, o		FATHER'S NAME	14. MOTHER'S MAIDEN NAME
her her nav		John Kohr	Mary Landis
ding t. Th	15.	WAS DECEASED EVER IN U.S. ARMED FORCES?  16. SOCIAL SECURITY NO.  17. Language of Service (15. — 36 — 2087B)	NFORMANI Mr. Elmer J. Weaver (Husband)
n, ai mi		No no nknown) (it yes give war ar adres ar service) 215-36-2087B	Riverside Drive, Salisbury, Maryland
signed by the attending physician and campletely filled in by the signed burial-transit permit. Then please remave carban papers. Pages burial, cremation, ar remaval, and in any event, within 72 hours after the signed burial.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	INTERVAL BETWEEN ONSET AND DEATH
by th ransi		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonory	= mbolus
d b Truck		2/00'0 DUE TO GO	Al
uria		Conditions, if any, which gave (b) OEn Eral 126d	14 r sr, osclerosis
		stating the underlying cause DUE 10	
been s the iar ta		last.	
this certificate has letached far use a Dept. of Health pr	No	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO 1	PERFORMED?
and	R	URINARY TRACT Injection	YES NO
	CERTIFICATION	20a. ACCIDENT WAS UNDERLYING ☐ 20b. DESCRIBE HOW INJURY OCCURRED.	(Enter nature of injury in Port I or Port II of item IB.)
cert ihed	AL C	(IF EITHER, NOTIFY MEDICAL EXAMINER)	(C. )
this eta	MEDICAL	Haur a.m. While Not While fact	CE OF INJURY (Hame, farm, ary, street, affice bldg., etc.)  20f. (City ar tawn) (Caunty) (State)
After 1 be d State	2	p.m. 19 atwark 🗀 atwark 🗀	
d b		21. I certify that (I) (this hospital) attended the deceased fram	t death accurred at 1070M, fram causes and an the date stated abave.
10 th		saw the deceased alive an SAN 26 1967, and that 22a. SIGNATURE	22b. DATE SIGNED
3. S.		Thomas C. Hell In. M.	ATTENDING MED. STAFF
ed led		22c. PHYSICIAN'S	22d, ADDRESS Al O I
RAL be		NAME (Type) Dr. Thomas C. Hill, Jr.	Rine Bluff Rd., Solisbury. Md.
FUNERAL DIRECTOR: After this certificate has been director, page 3 should be detached for use as the should be filed with the State Dept. of Health priar to	230	D. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR	
Sign N		Burial Jan. 29,1967 Hebron Cemete	ry Hebron, Maryland
= AT	24	4. FUNERAL DIRECTOR ADDRESS	2Sa. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE
VR A15 (4) 20 M 1/66		HOLLOWAY & COMPANY, SALISBURY, MARYLANI	DATEAN 30 1967 Icharles Judge

death certificate be executed within 24 hours after death. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the **other**ding physician and campletely filled in by the funeral director, page 3 should be detached far use as the burial-transit permit. Then please remove carban papers. Pages J and 2 should be filed with the State Dept. of Health priar to burial, cremation, ar removal, and in any event, within 72 hours after death. Page 4 may be retained by the haspital ar attending physician.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 01525 CERTIFICATE OF DEATH 01522 and 2 be executed within 24 hours after death and campletely filled in by the funeral remave carban papers. Pages 1 and in any event, within 72 hours after deal 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. STATE Maryland a. COUNTY b. COUNTY Caroline Wicomico MARYLAND b. CITY OR TOWN (If outside carporate limits, c. CITY OR TOWN (If outside carparote limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 16 write RURAL and give nearest town) Federalsburg days Salisbury d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Rt. #1, Box 175 Deer's Head State Hospital YES NO X 3. NAME OF First Middle 4. DATE Manth Year DECEASED 1967 Edward WELLS (Type or print) January Eugene DEATH IF UNDER 1 YEAR S SEX 6. COLOR OR RACE 9. AGE (In years IF UNDER 24 HRS. 7. MARRIED DATE OF BIRTH NEVER MARRIED last hirthday) Months Haurs Davs July 7, 1926 White WIDOWED DIVORCED Male 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (Caunty & State, or fareign cauntry) 12. CITIZEN OF WHAT during most of working life, even if retired)
Employee Caroline Farms INDUSTRY COUNTRY? please physician Federalsburg.Md. (Poultry Processing) USA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME remayal, attending pny-Thomas G. Wells Mildred M. Nichols 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. requires that the death permit. (Yes, no, or unknown) ((If yes give war or dotes of service) 215-20-2675 Mrs. Thomas G. Wells, Federalsburg, Md. Yes INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) ONSET AND DEATH burial-transit PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (6) Retroperitoneal Reticulum Sarcoma with signed by 5 months metastases DUE TO Conditions, if ony, which gove rise to immediate cause (a). **DUE TO** stating the underlying cause **10 HOSPITAL OR ATTENDING PHYSICIAN:** The law re Page 4 may be retained by the haspital ar attending as the TO FUNERAL DIRECTOR: After this certificate has been last. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) far use YES 🔽 NO 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part 1 or Port II of item 18.) detached (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (City or town) (County) (Stote) Hour o.m. factory, street, affice bldg., etc.) Nat While ot wark should be 21. I certify that (I) (this haspital) attended the deceased fram January 9, 1907, to January 17, 1967, that (I) (we) last saw the deceased glive an January 17 19 67, and that death accurred at 630 AM, from causes and an the date stated above. 22b. DATE SIGNED 22a SHGNATURE ATTENDING MED. DIRECTOR STAFF PHYS. director, page 3 shauld be filed v M.D. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Dr. A. C. Mitchell Deer's Head State Hospital, Salisbury, Md. 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Tawn) 23a. BURIAL, CREMATION, (County) (State) REMOVAL (Specify) Jan. 21, 1967 Hill Crest Cemetery Federalsburg 25h REGISTRAR'S SIGNATURE ADDRESS 2Sa. REC'D BY REGISTRAR



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1 MARYLAND CERTIFICATE OF DEATH death. funeral PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) b. COUNTY by the financial Pages 1 urs after after Wicomico Maryland Wicomico MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) oon papers. Pag within 72 hours hours Salisbury Salisbury E d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) filled d. STREET ADDRESS e. IS RESIDENCE ON A FARM? 407 Lincoln Avenue NO X Lincoln Avenue completely i YES within NAME OF 3. First Middle Last DATE Month Year DECEASED event, (Type or print) GLENNA WASHINGTON WELLS DEATH January 19 67 executed 5. SEX 6. COLOR OR RACE 7. MARRIED 8. DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS | Isst birthday) | Months | Days | Hours | Min. remove NEVER MARRIED any and Days June 21,1912 Female WIDOWED DIVORCED White 10a. USUAL OCCUPATION (Give kind of work done) E 10b, KIND OF BUSINESS OR stelah lease r 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? be during most of working life, even if retired) and INDUSTRY phystella Dietitian Hospital Salisbury, Maryland USA death certificate 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME remova attending principles of the standard st Hilary Hearne Hattie Brittingham 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. this certificate has been signed by the attenteached for use as the burial-transit permit. Dept. of Health prior to burial, cremation, or (Yes, no, or unkown) (If yes give war or dates of service) Mr. William D. Wells (Husband) No 407 Lincoln Avenue, Salisbury, Maryland CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN that the ONSET AND DEATH DEATH WAS CAUSED BY: PHYSICIAN: The law requires that to the hospital or attending physician. IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which (b) gave rise to Immediate DUE TO cause (a), stating underlying cause last. CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? NO X YES 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) detached State Dept. MEDICAL TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Hour a.m. After Not While retained by at work at work pluods FUNERAL DIRECTOR: A director, page 3 should should be filed with the 21. I certify that (I) (this hospital) attended the deceased from 1965 and that death occurred at 9:20 M. from the causes and on the date stated above. saw the deceased alive on 22a. SIGNATURE 22b. DATE SIGNED STAFF M.D. PHYS DIRECTOR PHYS. Jan. 16 1967 4 may PHYSICIAN'S director, p ADDRESS NAME (Type) Dr. Stedman Smith Salisbury, Maryland Page 4 BURIAL, CREMATION. 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) REMOVAL (Specify) Burial 2 Jan. 17, 1967 Parsons Cemetery Salisbury, Maryland FUNERAL DIRECTOR ADDRESS REGISTRAR'S SIGNATURE REC'D BY REGISTRAR 25b. VR A15 (4) SALISBURY, MARYLAND HOLLOWAY & COMPANY. 15M 4-64

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01527 FOR STATE HEALTH DEPT. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY delay is and 3 to o. STATE b. COUNTY Wicomico of Delaware death. MARYLAND Department c. CITY OR TOWN (If outside corporate limits, write RURAL and give neares town) b. CITY OR TOWN (If outside corporate limits. c. LENGTH OF STAY IN 16 write RURAL and give nearest town) after Millsboro Salisbury d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e. IS RESIDENCE ON A FARM? d. STREET ADDRESS Office alang with farm haurs DOA Peninsula General Hospital Item 18. Give Pages 24 haurs after death. 3. NAME OF First Middle 4 DATE Month lost Doy Year DECEASED the CHARLES White 1-8-67 19 within (Type or print) DEATH with 1 S SEX 8. DATE OF BIRTH IF LINDER 1 YEAR 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 9. AGE (In years IF LINDER 24 HRS lost birthdoy) Months Doys Hours 6-27-32 WIDOWED DIVORCED event 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT during most, of working life, even if retired) COUNTRY? INDUSTRY LABORER 1151 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME be executed within penci pub 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) ((If yes give wor or dates of service) ar remayal. pending 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN burial-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Hemorrhage due to rupture of liver IMMEDIATE CAUSE (o) used as a burial-tran ı burial, crematian, a This certificate shauld DHE TO Conditions, if ony, which gove rise to immediate couse (a) DUE TO stoting the underlying couse WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) please execute the certificate. YES X NO D 4 should be 20o. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) agent, prior PRIMARY CONTRIBUTING Driver of auto involved in head-on collision. CAUSE OF DEATH 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Day, Year foctory, street, office bldg., etc.) FUNERAL DIRECTOR: Page Selbyville Del. ot work at work designated 21. I certify that I took charge of the remains described above, held an Autapsy [X], Inspection X Inquiry X ond in my opinion may be retained far death resulted from: Natural causes Accident X Suicide Homicide [ Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE TO DEPUTY January 13, 1967 DEPUTY MEDICAL EXAMINER X Health ( Camden Ave. . Lisbury. Md. Address (Street, city, town, or county) 23o. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) 0 2So. REC'D BY REGISTRAR VR A15ME (5) on-Gray Melson Funeral Home, Frankfort, Delone JAN 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral and 2 executed within 24 hours after death. death/ USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) PLACE OF DEATH 1. a. COUNTY b. COUNTY Pages 1 urs after b. CTTY OR TOWN (if outside corporate limits, write RURAL and give nearest town) MARYLAND c. LENGTH CF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) by oon papers. Pag within 72 hours .⊑ Fruitland filled d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET AOORESS e. IS RESIDENCE ON A FARM? Poplar Street NO X YES completely carbon NAME OF First Middle DATE Month Year Oay DECEASED (Type or print) DEATH 1967 an and con 6. COLOR OR RACE SEX OATE OF BIRTH AGE (In years | IFUNDER 1 YEAR | IFUNDER 24 HRS last birthday) | Months | Oays | Hours | Min. 7. MARRIEO NEVER MARRIED any WIOOWEO X DIVORCED 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ξ 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CIŤIŽEN OF WHAT physician in please INOUSTRY COUNTRY? and C OMICO D HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate Page 4 may be retained by the hospital or attending physician. 13. FATHER'S NAME 14. MOTHER'S MAIOEN NAME remova signed by the attending plurial-transit permit. Then 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unkown) ((If yes give war or dates of service) transit permit, cremation, or n 16. SOCIAL SECURITY NO. INFORMAN 17. Address AN 18. CAUSE OF OEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: 3 des IMMEDIATE CAUSE (a) burial DUE TO buri Conditions, If any, which (b) TO FUNERAL DIRECTOR: After this certificate has been director, page 3 should be detached for use as the b should be filed with the State Dept. of Health prior to b gave rise to Immediate **OUE TO** cause (a), stating the underlying cause last. (c) CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO OEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMEO? NO S YES 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURREO. (Enter nature of injury in Part I or Part II of Item 18.) MEDICAL TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Hour a.m. While Not While at work p.m. 19 at work 21. I certify that (I) (this hospital) attended the deceased from JAN 1962 105BN and that death occurred at 1210 saw the deceased alive or AM. from the causes and on the date stated above. 22a. SIGNATURÉ DATE SIGNED 22b. ATTENDING STAFF M.D. PHYS. OIRECTOR ! PHYS. PHYSICIAN'S NAME (Type) 22c. 22d. ADORESS NAME OF CEMETERY OR CREMATORY LOCATION (City, town or county) (State) 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. 23d. REMOVAL (Specify) REC'O BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 24. FUNERAL OIRECTOR ADDRESS 25a. VR A15 (4) OATE 20M 1/65

